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1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 6876C,

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	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 yours after death. Page 6 may be r	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fixed in by the funeral director, page 5
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	8	1. DECEDENT'S NAME (PIST, MICHOR, LIBS) C ERGA 4. SOCIAL SECURITY NUMBER	ORIAND S. SEX S. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF MONTH 10 7. DATE OF	28 28	95	800 P M
Pis		1	1 🗆 M 2 X F	31 YRS.	MONTHS DAYS	HOURS MIN.	(Month, D	oy. Year)	Germa	
, 2, 3 should	TOR		11901 Georg			or location of de	ATH		ontgo	
it. Pages 1	DIRECTOR	10e. STATE 10b. COUNTY	gomery		Rockvil					0d. INSIDE CITY LIMITS? PES 2 NO
ansit perm	FUNERAL	14213 Chadwick Lar	ie		10	20853		10g. C	U.S.A	
the burial-transit permit. Pages 1,	B	11. MARITAL STATUS 1 Never Marited 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR O	2 NO	If yes, s	CENDENT OF HISPAN Pecify Cuben, Mexical S 2 NO Specify	n, Puerto Rica		14. RACE - Black, V Specify: Whit	
fixed in by the funeral director, page 5 should be detached for use as on, or removal. The medical examiner must be notified at once.	COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		16e. DECEDENT'S U (Give kind of we life. Do NOT use Homema	ork done during m retired.)			wn Home	NDUSTRY	
d be detach	ш	17. FATHER'S NAME (First, Middle, Last) Ferde Palke		Homem	IKCI	16. MOTHER'S NAI	ME (First, Midd	lle, Maiden Surname,		
5 should notified	TO B	19e. INFORMANT'S NAME (Type/Print)				and Number or Rural F				0050
ector, page must be r		Paul Orlando 20e. METHOD OF OISPOSITION 1X Burlel 2 □ Cremetton 3 □ Femore	of from State	b. PLACE AND DATE OF	DISPOSITION (N		OATE	20c. LOCATION -	- City or Town	n, State
al direct		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	——————————————————————————————————————	ate of Hea	22. NAME A	ND ADDRESS OF FAC	CILITY			,Maryland
al. examiner		sh LC	22			is J. Col				
y fited in by the tipn, or removal the medical		23. PART L. Enter the diseases, pr co shock, or heart fallure. II IMMEDIATE CAUSE (Final disease or condition	st only one cause on e	each line.	et enter the me	ode of dylng, such	as cardiac	or respiratory a	nrrast,	Approximate Interval Batween Onset and Death
ompletely I. cremati event, t		resulting in death) a.	Malignant I DUE TO (OR AS	Lymphoma consequence of	:					Wks.to Months
sician and con prior to burial. traumatic er	ATION	Sequentially list conditions, if any, leading to immediata cause. Entar UNDERLYING	Congestive DUE TO (OR AS	Heart Fa:						Wks.
ending physical Hygiene property or other t	ERTIFICATION	CAUSE (Disease or Injury that Initiated evants resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF)	:					
een signed by the attending physician and completely files of Health and Mental Hygiene prior to burial, cremation, shows any Injury, or other traumatic event, the	MEDICAL CI	PART H. Other significant conditions Chronic Obstructi				ng causa given in		e. WAS AN AUTOPS PERFORMED? YES 2 NO	C	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 27 NO
e Dept.	IAN:	25. WAS CASE REFERRED TO MEDICAL			28. P	LACE OF OEATH (Che	ack only one)			
ertificate h the State [or item	HYSICI	1 YES 2 NO	HOSPITAL:	patient 3 DOA		ne 5 Residence				
fter this o eath with marked,	ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY W	JURY AT ORK? YES 2 NO	28d. DESCR	BE HOW INJURY O	CCURED	
ECTOR: Aft s after de:	ETED E	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spe	Y — At home, farm, at ocify)	reet, fectory, offi	ca		ON (Street and Numb bwn, Stete)	per or Rural Rou	ite Number,
THE FUNERAL DIRECTOR: After this certificate has by filed within 72 hours after death with the State Dept. PORTANT: If Item 28 is marked, or Item 23 is	COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI MEDICAL EXAMINER:	AN: To the best of my know On the beele of examination							ind menner ee stated.
TO THE FUNERA be filed within 7 IMPORTANT:	BE 0	29b. SIGNATURE AND TITLE OF CERTIFIER	Midle	hun M	0	29c. LICENSE NUM	- 4			fonth, Day, Year)
2 9 X	10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OR	EATH (ITEM 27) (Type,	Print)	D0240	4		october	R 30, 1995
		Albert H. Grollman	1, M.D. 1	106 Spring	g Stree	t Silver	Spri	ng,Maryl	and 2	20910
40		OCT 31 1995	File dands	Rardall						
										DHMH-16 Ray 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

NDING P	Unit Tri United And Internal Residential and See Brownian and Residential And See See See See See See See See See Se	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR		STATE OF N		/ DEPAR					MENTA	L HYGIEN REG. NO	_		
3	1. DECEDENT'S NAME (First,									2. DATE	E OF DEATH		YEAR	3. TIME OF DEATH
9.			O'Neil							100	mber 4			2:30P. M
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	last birthday)		R 1 YEAR	# UNDER	24 HRS.	7. DATE	OF BIRTH	•	8. BIRTHE	PLACE (State or Foreign
93	213-54-6265	5	1 🗆 M 2 💢 F	46	YRS.	MONTHS	DAYS	HOURS	MIN.	Jani	uary 5	1949	Country	y rv1and
	9a. FACILITY NAME (If not ins	stitution, give s	treet and number)			9b. CIT	Y, TOWN C	R LOCATIO	ON OF DE		aary J		NTY OF DE	
E I	Mediplex 1	Nursin	g Center			G:	aithe	rehi	ro					
DIRECTOR	RESIDENCE OF DEC						TEHE	1300	118			PIO	ntgo	mery
H	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
	Maryland	Fred	erick		Mo	unt	Airy	,						1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER						101	ZIP CODE	E			10g. CITIZ	ZEN OF W	HAT COUNTRY?
E	4125 Larson	n Lane						2	1771			11	S.A.	
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	. WAS DEC	ENDENT O	F HISPAN	IC ORIGI	N? (Specify Yes			- American Indian, White, etc.
	1 Never Married 2 🔀	Married	FORCES? 1 IF YES, GIVE W		NO		If yes, spe	cify Cube	n, Mexica	n, Puerto	Rican, atc.)			
ВУ	3 Widowed 4 Divor	rced					,.20	2 21 110	Specify	,.		- 1	эрвсту	w White
COMPLETED	15. DECE (Specify only	EDENT'S EDU	CATION	16a.	DECEDENT'S	USUAL C	OCCUPATIO	N		168	b. KIND OF BUS	SINESS/IND	USTRY	
ш	Elementary/Secondary (0-		College (1-4 or 5 +	,	(Give kind of silfe. Do NOT us	e retired.)	during mo:	st of workin	g					
AP	12		1	0	wner	- Op	erat	or			Lega1	Serv	vices	3
Š	17. FATHER'S NAME (First, Mil	iddle, Last)				-			IER'S NA	ME (First,	Middle, Malden		- 1000	
BE C	Cherry (C. Gu	inn					E1	izab	eth	Ha1e			
8	19a. INFORMANT'S NAME (Ty	/pe/Print)			19b. MAILING	ADDRES	S (Street a				ber, City or Tow		Code)	
2	R. Steven (Neil									Airy, M			21771
	20a METHOD OF DISPOSITION	ON		20b, PLAC	E AND DATE	OF DISPO	SITION/Na	me of		DAT		CATION - (
	1 △Burlel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other /	n 3 □ Remo	ovel from State	cemetery, c	cremetory or o	thar place	emet	0737		1				
	21. SIGNATURE OF FUNERAL		ENSEE .		010	22	NAME AN	D ADDRES	S OF FA	CILITY				Maryland
	1	7	Mrs.		20	C	lin	L. M	oles	wort	h,P.A.	, Fur	nera]	L Home
	prest	4.	Villes	nus		2	6401	Rid	ge R	oad.	Damas	Cus.	Mary	land 20872
	23. PART I. Enter the dis	seases, or c	omplications that List only one cau	caused the	desth. Do r	not ente	r the mo	de of dyi	ng, auci	h sa cen	diac or respi	ratory arre	est,	Approximate
- 1	IMMEDIATE CAUSE (Fin		comp one cas	, ac on each in	110.									Interval Between Onset and Death
	disease or condition resulting in death)	→ .	MAL DUE TO	IGNIA	NT	AS	TON	0.1	MA	nA	.66	ADE	- 711	6 mns
	rounding in dutin	•	DUE TO	OR AS A CONS	SEQUENCE O	F):		cy.	1000	111	100	ADC	144	011103.
z			b.											
RTIFICATION	Sequentially list condition if any, leading to immed		DUE TO	OR AS A CONS	SEQUENCE OF	F):								
S	cause. Enter UNDERLYII CAUSE (Disease or Injur	NG												
E	that initiated events		DUE TO	OR AS A CONS	EOUENCE O	ት)፡						······		
E	reaulting in death) LAS1	r l	d											
O	DADT II Other election													
¥.	PART II. Other significar	CONGREGA	s contributing to	deeth but no	t resulting	in the u	nderiying	cause g	iven in	Part I.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă											1 - YES 2	NO		COMPLETION OF CAUSE OF DEATH?
¥											·			1 _ YES 2 _ NO
PHYSICIAN: MEDICAL	DID TOBACCO US	SE CONTE	RIBUTE TO CA	USE OF DE	ATH YE	S	NO 🗷	UNC	ERTAIN	۱ 🗆				
ĕ.	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		26. PL	ACE DF DEAT									
Sic	1 YES 2 NO		HOSPITAL:	ER/Outpatient	3 DDA	OTHE Nu	R: raing Home	5 🗆 Re	sidence	6 Othe	er (Specify)			
ξl	27. MANNER OF DEATH		28s. DATE OF (Month, Da	INJURY	28b. TIM	E OF	28c. INJU	JRY AT			SCRIBE HOW II	NJURY OCC	URED	-
BY		Pending nvestigation	(Month, De	ly. rear)	INJ	URY M	1 🗌 Y	ES 2	NO					
	2 Sulates	Could not be	28e. PLACE OF	FINJURY — At	home, ferm, s	treet, fac	tory, office				ATION (Street &	nd Number	or Rural Ro	oute Number,
		letermined	bunding,	etc. (Specify)					_	City	or Town, State)			
Ë	29a. CERTIFIER	EVING BUVER	NAM: To the heat of	(m. 1410-211).	4 -4							V-12-12-12-12-12-12-12-12-12-12-12-12-12-		
COMPLET			CIAN: To the best of											end manner as stated.
8					- mresugado	u, iii my	ориноп, си				and place, and	due to the	cause(s)	end manner as stated.
B	29b. SIGNATURE AND TITLE	OF CERTIFIER	-71			. A		29c. LICE						Month, Day, Year)
6	marle	ne	1. Hau	ma	n. N.	W		MD	3/	36	2	1	1-4	-95
- 1	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	OF DEATH (IT	FM 20 (Time	Deinel								

HAYMAN, MD. 501

32. REGISTRAD'S SIGNATURE

Structure Randall

MARLENET. HT 31. DATE FILED (MONTH), Day, Year) NION 06 1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bund-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bund. Cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR				OF DEATH	REG. NO.	_				
	1. DECEDENT'S NAME (First, Middle, Last)		X- 1			2. DATE OF OEATH		3. TIME OF DEATH			
	JOHN WI	LLIAM	O'NE	AL		NOVEMBER	4,199	1928 P M			
	4. SOCIAL SECURITY NUMBER	T T	AGE (In yrs. last birthday)	7	AR IF UNDER 24 HRS.	7. OATE OF BIRTH	8. B	NRTHPLACE (State or Foreign			
	079-10-8446	1 💢 M 2 🗆 F	83 YRS.	MONTHS DA	YS HOURS MIN.	Nov. 3, 19	12 1	Missouri			
	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TO	WN OR LOCATION OF DI		9c. COUNTY				
DIRECTOR	CITIZEN'S NURS	ING HOME		FRED	ERICK		FREDE	ERICK			
EC	10a. STATE 10b. COUNT	Υ	10c. CI	TY, TOWN OR L	OCATION			10d. INSIDE CITY LIMITS?			
10	Maryland Fre	derick	F	rederi	ck			1 YES 27 NO			
AL	10s. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
FUNERAL	7093 Catalpa Roa	d			21703		U.S	.A.			
5	11. MARITAL STATUS	12. WAS DECEDENT EV FORCES? 1	ER IN U.S. ARMED			NIC ORIGIN? (Specify Yes	or No — 14. I	RACE — American Indien, Black, White, atc.			
B⊀	1 Never Merried 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR	OR DATES		a, specify Cuban, Maxice YES 2 NO Specif			Specify: White			
COMPLETED	15. OECEDENT'S EDU (Specify only highest grade		16a. DECEOENT			16b. KIND OF BUS	SINESS/INDUST	RY			
Ē	Elementary/Secondary (0-12)	College (1-4 or 5 +)	iile. Do NOT	use retired.)	ng most of working			1			
AP.		5	Contrac	ct Spec	ialist	Aerospa	ce Busi	ness Group			
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Sumame)				
BE (W	. Claude	0'Neal		Grac	e E	Ellery				
TO E	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow		·			
-	Mrs. Sonia L. O'N	eal	7093	Catalp	a Road, Fr	rederick, M	ID 2170	3			
	20s. METHOD OF DISPOSITION 1 To Burlet 2 Cremation 3 Rem	noval from Stata	20b. PLACE AND DATI cemetery, cremetory or		N (Name of	DATE 20c. LO	CATION — City	or Town, Stata			
	4 Donation 5 Other (Specify)		Mount Oli	vet Cer	netery, Nov	.7.1995 F	rederi	ck, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LI	W P.D.	M00703	Kee		ord P.A. F					
	23. PART i. Enter the diseases, or	complications that e	head the deeth. Do					k, MD 21701			
	shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	PERFORATE	D DUODENAL L AS A CONSEQUENCE	ILCER				Interval Setween Onset and Daath			
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
	PART II. Other significant condition					Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS			
DICAL	ATHEROSCLEROTIC CAR	DIOVASCULAR D	DISEASE, DIA	ABETES ME	ELLITUS	I X YES		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEC	DEMENTIA, STATUS P	OST FEMUR FRA	CTURES					1 TES 2 NO			
	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEATH	ES NO	UNCERTAI	N⊠					
X X	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DE	ATH (Check only	one)						
Sic	1 X YES 2 NO	HOSPITAL:	NOutpatient 3 DOA	OTHER:	Home 5 Realdence	8 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJ (Month, Day,	URY 28b. T	ME OF 28	c. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCURE	ED			
ВУ Р	1 XX Natural 5 Pending 2 Accident Investigation	(MONA, Day, 1	out)		YES 2 NO						
	3 Suicida 8 Could not be determined	28a. PLACE OF IN building, etc.	JURY — At home, farm (Specify)	, street, lectory,	offica	281. LOCATION (Street City or Town, State		lural Route Number,			
COMPLETED		SICIAN: To the best of my ER: On the bests of exam						nuse(s) and manner as stated.			
BEC	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NU	MBER	29d. DATE SIG	GNED (Month, Day, Year)			
	Dennis). Churte			O.C.M	.E.	NOVE	MBER 6,1995			
10	30. NAME AND ADDRESS OF PERSON WITH					imore, Ma					
	31. DATE FILED (Month, Day, Year) NOV 1 3 1995	Jahr Dane	SIGNATION ROUGH	. Dere	oc, Bare	inore, He	ary ruii	W 21201			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	. Pages 1, 2, 3 should		
attending physician.	se as the burial-transit permi		
VSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician.	L DRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		and the first of an annual
irs after death. Page 6 may t	n by the funeral director, pag	removal.	I thouse 30 to manufact our library care inference on address excession by modified accompany to martilland at any
be executed within nou	iclan and completely filled i	rior to burial, cremation, or	my othe bearing alternations
ires that the death certificat	signed by the attending phys	tealth and Mental Hygiene p	souther so sential was on
PHYSICIAN: The law requ	r this certificate has been a	h with the State Dept. of h	sade of stone 29 about
AL OR ATTENDING	L DIRECTOR: Afte	2 hours after deat	1 thom 20 to me

		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGI		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATI	1	3. TIME OF DEATH
		RICHARD WILLIAM O	LIVER, SR.				OCTOBER	30 1995	1:00 A. M
		, and the second second		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea	8.0	BIRTHPLACE (State or Foreign Country)
P		214 01-2302	1 M 2 □ F 8(YRS.	MONTHS DATS	HOURS MIN.	DEC 13 1		MARYLAND
3 should	m	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH
1, 2, 3	DIRECTOR	639 HENDERSON AVE.			CUMBI	ERLAND		ALLEG	ANY
	Ä.	10a. STATE 10b. COUNTY		10c. C(1	TY, TOWN OR LOCA	ATION			10d. INSIDE CITY LIMITS?
.Ę.			EGANY	С	<u>UMB</u> ERLAN	ND ND			TAN YES 2 NO
020 physician. burial-transit permit. Pages	₹ S	10e. STREET AND NUMBER			10	of. ZIP COOE		10g. CITIZEN	OF WHAT COUNTRY?
ian. transi	FUNER	639 HENDERSON AVE	12. WAS DECEDENT EVER IN	1110 10110		21502		U.S	
020 ohysic burial-		1 Never Married 2 Married	FORCES? 1, YES	2 NO	If yea, a	pecify Cuban, Maxic	NIC ORIGIN? (Specify an, Puarto Rican, etc.)	RACE — American Indian, Black, White, alc.
215-0020 attending physician. se as the burial-trar	Β¥	3 Wildowed 4 Divorced	YES WW11	NIES	1 U YE	S 2 NO Speci	y:		Specify: WHITE
215 atten	밀	15. DECEDENT'S EDUCA (Specify only highest grade of		(Give kind of	USUAL OCCUPATI	ION ost of working	16b. KIND OF	BUSINESS/INDUST	TRY
2121 ital or atte	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	ise retired.)				
AND the hospital detached for once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		CELANES	E CORP C	OF AMERIC			/WAREHOUSE
YLA by the be det	S		TWED				AME (First, Middle, Ma		
E 8 8 2	100	JAMES PLEASANT OL 19a. INFORMANT'S NAME (Type/Print)	I VER	19b. MAJLING	G AODRESS (Street		EMILY WH Route Number, City or		(e)
5 5 5	유	RICHARD W. OLIVER.	.IR.						LAND 21502
RE, may be or, page ast be		20a METHOD OF DISPOSITION t N Burlal 2 Cremation 3 Ramon	20b.		OF DISPOSITION (N			LOCATION — City	or Town, Stata
MOR ge 6 ma lirector, p		4 Donation 5 Other (Specify)	SU	NSET CE	METERY N	OV 2 199	5 cm	MBERLAND	MARYLAND
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		21. BIGHATURE OF FUNERAL SERVICE LICE	1 - 1L		22. NAME A MERRT	TT-ADAMS	FUNERAL	HOME.	
BALT er death. the funera val.		Rale Z. 1	lemb	-2	404 D	ECATUR S	TREET CUN	BERLAND	MARYLAND
hours af the in by or remo		23. PART I. Enter the diseases, or co shock, or heart failure. L IMMEDIATE CAUSE (Final	int only one cause on ea	the death. Do	not enter the m	ode of dying, suc	ch as cardiec or re	espiratory errest,	Approximate interval Between Onset and Death
ely nati		disease or condition resulting in death)	OUE TO (OR AS	CONSCOUENCE	mia o	mase	un		<4poin
68760 ecuted with and complet burial, cren atic event	z	C .	Coames	Horas	4 Use	dal			> 10 Means
OX 68 e be execut siclan and c nior to buri	RTIFICATION	Sequentielly list conditions, if any, leading to immediate	O DUE TO JOR ANA	CONSEQUENCE	TA A	0.10	· M.11	2	- 20
BO ficate b physici ne prio	S	CAUSE (Disease or injury	mwan	aumo	WW O	anna	1 //11/11/03	W	100 gruy
o gin di	E I	that initiated evanta resulting in death) LAST	O DOE TO (OH AS A	CONSTIQUENCE O	F):			- 100	
D = 5 0	CE	d.							i
RDS, at the dea by the att and Menta y injury.	AL	PART ii. Other significant conditions	contributing to deeth be	ut not resulting	in the underlyin	ng cause given in		AN AUTOPSY FORMEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
9 5 8 E	EDIC						1 🗌 YE	S 2 000	COMPLETION OF CAUSE OF DEATH?
RECO w requires th been signed or, of Health shows an	ME	DID TODA COO HEE CO					_		1 TYES 2 NO
> = = =	AN	DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE OF		ES NC	F-2		
E at at E	SICIAN	EXAMINER?	HOSPITAL:	etiont 1 DOA	OTHER:	LACE OF DEATH (C)			
F 5 5 5	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIR	IE OF 28c. IN	JURY AT	8 Other (Specify) 28d. DESCRIBE HO	W INJURY OCCUR	ED
NG PHYS frer this coath with marked,	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	110		ORK? YES 2 NO			
0 5 4 9 "		3 Suicide 8 Could not be	28s. PLACE OF INJURY building, stc. (Spec	— Al home, larm,	street, lactory, offic	ca	28f. LOCATION (Str. City or Town, S	set and Number or F	Bural Route Number,
OR ATTEN OR ATTEN DIRECTOR: hours after Item 28 I	1	4 Homicide datarmined		**//			City or lown, S	iale)	
DIV L OR A L DIREC Pours	COMPLETE	29a. CERTIFIER 1 CERTIFYING PHYSIC	AN: To the best of my knowl	ledge, death occur	red at the lime, date	a and place, and due	to the cause(a) and	manner as stated,	
HOSPITAL FUNERAL within 72	OM								use(a) and manner as stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	w I	296. SIGNATURI AND TITLE OF CERTIFIER	100,400	. 6		29c. LICENSE NU	MBER	29d. DATE SIG	GNED (Month, Day, Year)
P R B W	TO B	SUM h	unmi	114		1/60	241	▶ /10 -	30-95
1(4)	-	30. NAME AND ADDRESS OF PRISON WHO							
pds !		DR. TERRY WILLIAMS			MEDICA	L BUILDI	NG CUMBER	LAND MAI	RYLAND 21502
		NOV 01 1995 A	32. REGISTRAR'S SIGNI	robail					

THE HOSPITAL THE FUNERAL filed within 72 h	The second of th	ID THE MUSTIAL DIR ALIENDING PRISIDING: THE IOW TEQUINES DIRECTOR TO THE TRANSPILLATION OF THE PROPERTY OF THE	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--	--	--	--	--

	FOR STATE REGISTRAR	STATE OF N	MARYLAND /		RTMENT				MENTAL	HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) Alberta M. Pet	chel								ber :	Ĭ7, 1		7:00 A.M
	4. SOCIAL SECURITY NUMBER 202-18-4114	5. SEX 1 M 2 TF	6. AGE (In yrs. las	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE ((Month)		6.	BIRTHPLA Country)	CE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give st 324 Moss Stree						ake				9c. COUNTY	OF DEATH	1
DIRECTOR	10a. STATE 10b. COUNTY	ci1			hes:			Ci+	V.			200	I. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	10e. STREET AND NUMBER 324 Moss Stree	t					ZIP COD				10g. CITIZEN	OF WHAT	
a									American Indian, hite, atc.				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12)		(G He.	ive kind of . Do NOT u	work done ise retired.)	during mo	ON st of worki	ng	16b.		Home		
ш	17. FATHER'S NAME: (First, Middle, Last) Dory Loyd									diddle, Maiden ters!	,		
TO B	19a. INFORMANT'S NAME (Type/Print) Elaine Brownhi	.11									n, Stere, Zip Co Pa.		14
	20a. METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		20b. PLACE other place St. R	ece)	of	Lin	ia C	em			cation — city		
	21. SIGNATURE OF FUNERAL SERVICE LIC	LIV.					une			259 e E1	E. Naton,	Main	St., 21921
	23. PART i. Enter the discuss, or of shock, or hear fellure. IMMEDIATE CAUSE (Final	List only one cer	use on each ilne	b.	not ente	r the mo	de of dy	ing, suc	h es card	lec or respi	iretory errest	t,	Approximate interval Between Onset and Death
	disease or condition resulting in death)	DUE TO DUE TO	(OR AS A CONSE	OUENCE (OFI:	te	LWF	ARC	120.	N			
ATION	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING	DUE TO	(OR AS A CONSE	OUENCE C	OF):	reg	872	357	26.	Au I	1 8 PM	P 10	
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE () [[C	· CA	MIC) V N	su	AIR K	Y SLA	8k	
اب	PART II. Other significant condition	s contributing to	death but not i	resulting	in the u	nderlyin	g cause	given in	Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS
MEDICA													
PHYSICIAN:	Z5. WAS CASE REFERRED TO MEDICAL EXAMINER?												
	1 VES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending	28a. DATE Of (Month, D	ER/Outpetlant 3 F INJURY Day, Year)	28b. Til		28c. IN.	JURY AT ORK? YES 2		6 Othe		NJURY OCCUP	RED	
TED BY	3 Suicide 6 Could not be detarmined 286. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)												
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best o											nd manner as stated.
O BE C	296. SIGNATURE AND TITLE OF CERTIFIE	niel					29c. LIC	ENSE NU	MBER LC 3	2	29d. DATE S	IGNED (M	onth, Day, Year)
I E	30. NAME AND ADDRESS OF PERSON WIT	COMPLETED CAL	SE OF BEATH ATE	M an /s-	o Onlost			-					

21921

Md.

118 North Street, Elkton,

Rolando

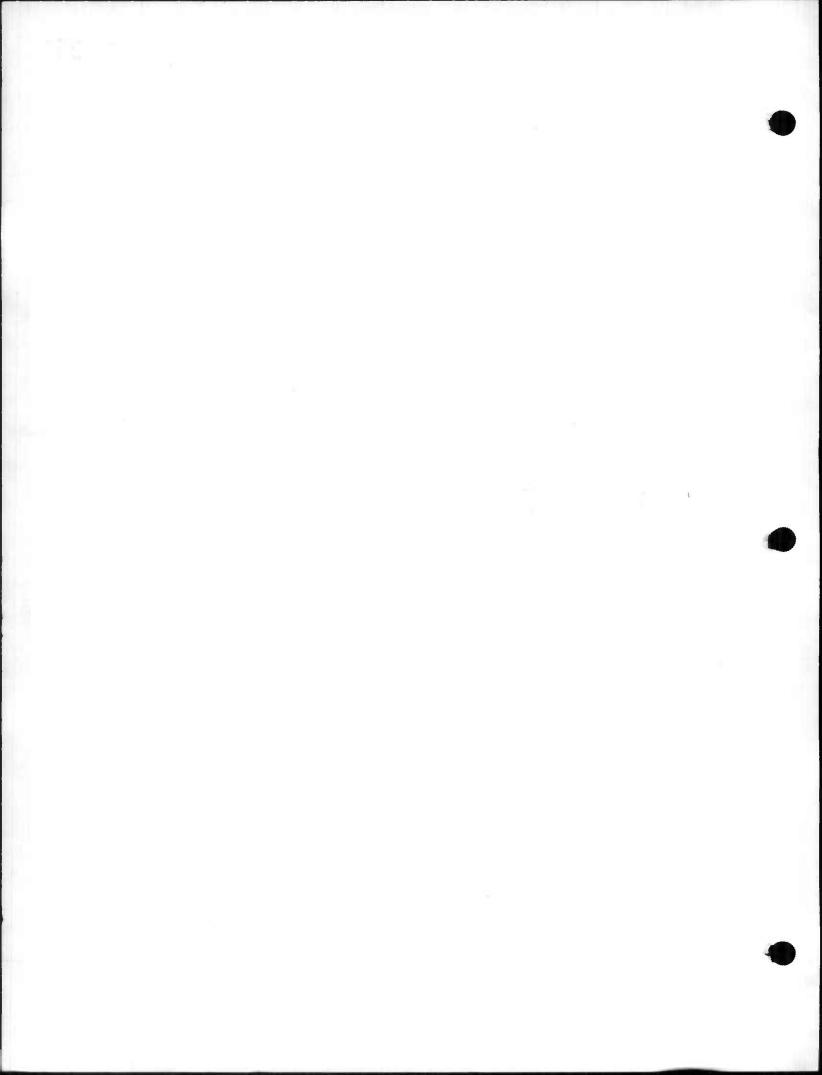
31. OCT 20 1995

Α.

Najera,

M.D.

32. PEGISTRAR'S SIGNATURE



FOR 1 - STATE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

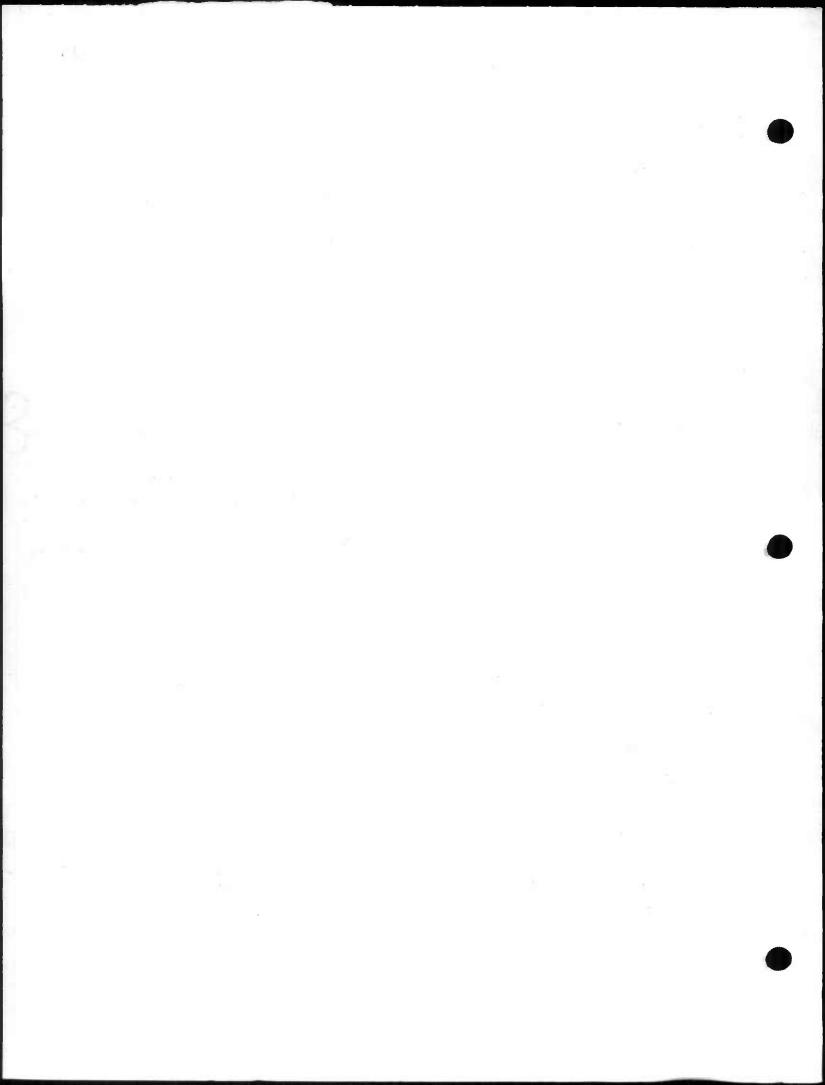
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

111	REGISTRAR				ERIII	CALE	UF	DEA	l l'i	F	REG. NO.			
	1. DECEDENT'S NAME (First		Prapai		mawat					2. DATE OF MONTH	DA	, 19	95	3. TIME OF DEATH 6:36 A M
	4. SOCIAL SECURITY NUME 216-98-7819		5. SEX	6. AGE (In yrs 1	ast birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF 1 (Month, Di	ly, Year)	23	Country	PLACE (State or Foreign iland
	9a. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CITY	TOWN C	R LOCATI	ON OF DE		, 1		NTY OF DE	
DIPECTOR	Holy Cross	Hospit				Si	lver	Spr	ing			Mon	tgome	ery
3	10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN C	OR LOCAT	ION						10d. INSIDE CITY
	Maryland		ntgomery		S	ilve								LIMITS?
FUNERAL	3903 Elby S						101	209					haila	and
BY FUN	11. MARITAL STATUS 1 Never Married 2 3 X Widowed 4 Dive		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	ARMED NO		If yes, sp		ın, Maxice	NIC ORIGIN? (S an, Puerto Rica y		or No-		- American Indian, White, etc.
		EDENT'S EDU	ICATION	18. 1	DECEDENT'S	HOUAL O	CCUDATIO	DM .		185 81	ND OF BUS	IMEGE/IM	OUSTEV	1102411
-	(Specify on	ly highest grade	e completed)		(Give kind of He. Do NOT u	work done se retired.)	during mo	st of worki	ng	100. 1/1	ND OF BOS	PRINCOS/IN	DOSTRI	7.70
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 -	+)	Teach						Edu	cati	on	
N N	17. FATNER'S NAME (First, IV	Sicidia I not)			Teuen		_	10 MOT	HED'S NA	AME (First, Midd				
	Paew Pungpo									aelimp	no, marcon	Surranner		
IO BE	19a. INFORMANT'S NAME (nd Numbe	r or Rural	Route Number,				00006
ř	Vichai Pram							_	Apt	DATE			City or To	, MD 20906
	20a, METNOD OF DISPOSIT 1 X Burial 2 Crematic 4 Donation 5 Other	on 3 X man	novel from State	camatary, o	EANDDATE crematory or o	ther place)			11	1/3/95		gkok		hailand
	21. SIGNATURE OF FUNERA	AL SERVICE LI	CENSES	1	/					ollins				
_	Sim	TZ.	Sm	ulh	0					-				MD 20901
	ahpek, or f	ieart fallure	complications the	it caused the use Dn eech ii	death. Do	not enter	the mo	da of dy	ing, aud	ch as cardisc	or reapi	ratory a	rreat,	Approximate interval Between Onset and Death
	disease or condition reaulting in death)	→	a. Core	OR AS A CONS	AY	-tei	rγ	Di	sea	Sa				3 years
N	Sequentially list condi	tions	b				<u>'</u>							
CATIC	if any, leading to imme cause. Enter UNDERLY	diate	DUE TO	(QR AS A CONS	SEQUENCE C	F):								
CERTIFICATION	CAUSE (Disease or Injuthat Initiated events resulting in deeth) LAS		DUE TO	(OR AS A CONS	SEQUENCE C	rF):								
_			d							I				
EDICAL	PART II. Other signific		ns contributing to	death but no	t resulting	in the u	nderlyin	g ceuse	given in		PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Davis	1	cer leve							1	YES 2	NO		OF DEATH?
Σ	DID TOBACCO U				ATH Y	ES 🗍	NO [1 UNG	CERTAI	NΠ				1 TYES 2 NO
M	25. WAS CASE REFERRED				ACE OF DEA									
SIC	EXAMINER?		HOSPITAL:	ER/Outpetient	3 🗆 DOA	OTHE 4 Nu		ne 5 🗆 R	laaldenca	8 Other (S	(pecify)			
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE QI (Month, I		28b. TH	AE OF JURY		JURY AT DRK?		28d. DESCR	HBE NOW I	NJURY O	CCURED	
BY	Netural 5 Accident	Pending Investigation		DE IN HITTO		M		YES 2	_ NO		241 (2)			
	3 Suicide 8 4 Nomicide	Could not be determined		OF INJURY — At , etc. (Specify)	nome, tarm,	street, rac	tory, omi				Town, State)		er or Hurai F	loute Number,
COMPLETED	constitution of the consti		SICIAN: To the best of IER: On the bests of I) and manner as stated.
S I	296. SIGNATURE AND TITL	E OF CERTIF	ER S			1//	>	29c. LIC	ENSE NU	JMBER		29d. DA	TE SIGNED	(Month, Pay, Year)
10 86	MCLLL 30. NAME AND ADDRESS OF	E PERSON W	HO COMPLETED CAL	Les CE CEATH "	TEM 277/7-	M	0	D	25	080		•	10/2	9/95
	Frank	N.	Gravin	10,10	0313		corp	nia	A	ve, s	silv	er o	Spor	ing MD
	31. DATE FILED (Month, Day	0 1995	32 REGISTA	AR'S SIGNATURE	really		()					V	0
	. 0	0 1000	-0											DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

AL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	40	with th	APORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL DR ATTENDING PHY	THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with	APORTANT: If item 28 is marked

	1 - FOR STATE REGISTRAR	STATE OF MARYLAI		TMENT OF H			GIENE		
	1. DECEDENT'S NAME (First, Middle, Last)		10			2. DATE OF DE	ATH .		3. TIME OF DEATH
	EDWARD		Po	T3HDE	TI	OCTOBE	R 31,1	1995	12:01Am
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (in	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR (Month, Day,		6. BIRTN	PLACE (State or Foreign
	082-03-5212	1 🔀 M 2 🗆 F	37 YRS.	MONTHS DAYS	HOURS MIN.		4,1908		rmont
	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN OR LOCATION OF DE			9c. CO	UNTY OF D	EATN
DIRECTOR	Shady Grove Adve	ntist Hospit	al	Rockv	ille		1	Montg	omery
HH.	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCAT	ION				10d. INSIDE CITY LIMITS?
		gomery		aithersb					1 YES 2 X NO
FUNERAL	10e. STREET AND NUMBER		_	101	ZIP CODE		10g. C	ITIZEN OF W	VHAT COUNTRY?
N.	924 Beacon Square				20878	and the same of th			States
	1 Never Married 2 X Married	12. WAS DECEDENT EVER IN U FORCES? 1 X YES	2 NO	II yes, sp	ENDENT OF NISPAN scify Cuban, Maxica	n, Puerto Rican, e		Black	— Americen Indian, c, White, etc.
BY	3 Widowed 4 Divorced	1942 - 194		1 TYES	2 NO Specify	r:		Specia	White
	15. DECEDENT'S EDUCA (Specify only highest grade or	ATION	16a. DECEDENT'S	USUAL OCCUPATION		16b. KIND	OF BUSINESS/I	NDUSTRY	WHILE
딟	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	work done during mo se retired.)	st or working				1.00
M M	8		For	eman			Manufa	cturi	ng
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle,	Maiden Sumame)	
8	Louis	Pochetti				Teres		roggi	ni
6	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street a					
	Larry Pochetti 20a. METNOD OF DISPOSITION			meleaf C					
	1 N Burial 2 Cremation 3 Ramov	rel from Stata cemet	ery, crematory or o	OF DISPOSITION (Na other place)		1	Oc. LOCATION		
	21-BIGNATURE OF FUNERAL SERVICE LICE		lington	Nationa.	I Cemete:		Arlingt	on, v	/irginia
		01-(1)	0	DeVol Funeral Home					
	Menso	2000	way						, MD. 20877
	23. PART I. Enter the diseases, or co shock, or heert feliure. Li	ist only one ceuse on eed		not anter tha mo	da of dying, auc	h ea cerdlec o	reapiratory	arreet,	Approximate Interval Between
	IMMEDIATE CAUSE (Fine) disease or condition PNEUMONIA								Onaet and Death
	resulting in death)	DUE TO (OR AS A C							Meek
_		3 0 (OII NO X C	JOHOLOOLINGE C	,, _j .					
CERTIFICATION	Sequentially list conditions, If eny, leeding to immediate	DUE TO (OR AS A C	CONSEQUENCE C	PF):					
S	cause. Enter UNDERLYING CAUSE (Disease or Injury								
띨	that initieted events	OUE TO (OR AS A C	CONSEQUENCE C	PF):					
H H	resulting in death) LAST								
AL C	PART II. Other significent conditions	contributing to deeth but	t not resulting	in the underlying	g ceuse given in	Pert i. 24a. V	WAS AN AUTOPS	Y 24b.	. WERE AUTOPSY FINDINGS
<u>S</u>	PANCYTOF	EN IA					YES 2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	CHRONIC C		5 LU	NG D	ISEASE	5	123 2 13010		OF DEATH? 1 YES 2 NO
÷	DID TOBACCO USE CONTR					N D		- 1	
M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF OE	ATH (Check only one)					
SIC		HOSPITAL:	tient 3 🗆 DOA	OTHER: 4 Nursing Non	a 5 Realdence	6 Other (Spec	(fy)		
PHYSICIAN: MEDIC	27. MANNER OF DEATH	26a. OATE OF INJURY (Month, Day, Year)	28b. TII		URY AT	28d. OEŞCRIBE	HOW INJURY	OCCURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
	3 Suicide 6 Could not be	26e. PLACE OF INJURY - building, alc. (Specif)	At home, ferm, y)	atreal, lactory, offic	•	28f. LOCATION City or Town		ber or Rural f	Route Number,
립	200	IAN: To the best of my knowled							
COMPLETED	2 MEDICAL EXAMINER	: On the besis of examination	end/or Investigati	on, in my opinion, o	eath occured at the	time, date and p	eca, and due to	the cause(s	a) and manner as stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUI	MBER	29d. D	ATE SIGNED	(Month, Day, Year)
10	men	am mo			D-3	3224	100	ct3	1.1995
-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DEAT	TH (ITEM 27) (Typ	+401,	RINCIEN	MILE	402	- C-	
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TUBE	11401,	MUCH (7100	40)	000	2
	NOV 03 1995	Julia Davides							
	140 4 16 1992	Jana warmen	- work					-	DHMH-16 Rev 1/89



YEAR

.928 Connecticut

1995

9c. COUNTY OF DEATH

Montgomery

3. TIME OF DEATH

5:30

6. BIRTHPLACE (State or Foreign

М

P

REG. NO. 2. DATE OF DEATH DAY

BALTIMORE, MARYLAND 21215-0020

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

BOX 68760 DIVISION OF VITAL RECORDS, P.O.

Robert Wilmer Peck 28 October 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🔲 M 2 🗌 F 120-14-1466 67 March 15, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 11808 Idlewood Road Silver Spring 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 11808 Idlewood Road use as the burial-transit 20906 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-FORCES? 1 TYPES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried Il yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced 1947-1951 ED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only high ᆸ page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL Dispatcher Once. 17. FATHER'S NAME (First, Middle Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) ä Bartlett Samuel Peck Martha Susan Young notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Louise O. Peck 11808 Idlewood Road Silver Spring, Maryland hours after death. Page 6 may be be 20e. METHOD OF DISPOSITION
1 □ Burlel 22 □ Cremetion 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of must funeral director. Metropolitan Crematory 11/1/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY Francis J. Collins Funeral Home, Inc. 10 mes filled in by the fon. or removal. medicai 23. PART I. Inter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List only one ceuse on each line. ŏ **IMMEDIATE CAUSE (Final** other traumatic event, the disease or condition metastatic lung completely cancer reaulting in death) DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to it any, leading to immediate cause. Enter UNDERLYING the attending physical difference of CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST 0 injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL and a any signed the Shows r this certificate has been s in with the State Dept. of H arked, or item 23 show DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 YES 2 NO OTHER: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Raeldence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 1 Natural 5 Pending investigation 1 YES 2 NO ΒY After 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcida 00 8 Could not be DIRECTOR: A hours after d 4 Homicide 28 Ш item 29e. CERTIFIER

(Chark note)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMPL FUNERAL (HOSPITAL = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. PORTANT 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER HE 8 22420 α . D43083 conce 우 우 의 목 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9707 Medical Center Dr. #300 Rockville, MD George A. Sotos, M.D.

32. REGISTRAR'S SIGNATURE
DRIVELSON RONDOLL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

10d. INSIDE CITY 1 YES 2X NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: White 18b. KIND OF BUSINESS/INDUSTRY Petroleum 20906 20c. LOCATION - City or Town, State Alexandria, Virginia 500 University Blvd., W. Sil. Spr., MD 20901 Approximate interval Between **Onset and Death** months 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 | YES 2 | NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 10-30-95 DHMH-16 Rev 1/89

30+1

31. DATE FILED (Month, Day, Year) NOV 01 1995

1 - FOR STATE REGISTRAR

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DIVISION	The second of th
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		The second secon										rica. No	•			
		1. DECEDENT'S NAME (First SWAMI PREMAI		aka BRAI	нмасн	ΔRΤ	JOTIN				2. DATE MONT OCT	of DEATH	, 199	YEAR	3. TIME OF DE	
		4. SOCIAL SECURITY NUMBER		5. SEX	_	yrs. lest birti		VDER 1 YEA	R IF UNDE	R 24 HRS.	7 DATE	OF BIRTH	, 199		7:21	A
PIN		578-62-5043		1 📉 M 2 🗆 F	92		RS. MONT	HB DAY	HOURS	MIN.	JUN	h, Day, Year)	1903	Countr		roraign
3 should	œ	9a. FACILITY NAME (II not in		reet and number)								9c. COUN				
1, 2,	CTO	RESIDENCE OF DEC	EDENT										MONT	GOMI	ERY	
Pages	DIREC	MARYLAND	MONTE			- 1	10c. CITY, TOWN OR LOCATION						100		10d. INSIDE CIT	TY
ermit.		10e. STREET AND NUMBER	MONT	GOMERY			BETHESDA 101, ZIP CODE					10g. CITIZEN O			1 TYES 2	_
nsit pr	ERA	4748 WESTER	RN AVE			20816						IND		THAT COUNTRY?		
physician. burlal-transit permit. Pages	FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN	U.S. ARMED	S. ARMED 13. WAS DECENDENT OF HISPAN					N? (Specify Yes		14. RACE	- American In	dlan,
r attending phuse as the bu	B≺	1 Never Married 2		IF YES, GIVE V			XNO If yes, specify Cuben, Mexican, Puerto R 1 ☐ YES 2 ☐XNO Specify:					rrican, arc.j		Speci	r, White, etc.	N
or atte	TED	(Specify only	EDENT'S EDU			16a. DECEDE	nd of work de	one during	TION most of worki	ing	168	. KIND OF BU	SINESS/IND	USTRY		
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ed by		BANER								BANY	_	CHATT				_
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran medical examiner must be notified at once.		190. INFORMANT'S NAME (1 SRIMATI KA	MALA									ber, City or Tow A, MD.				
death. Page 6 may be funeral director, page xaminer must be		20e. METHOD OF DISPOSIT 1 Buriel 2X XCremetic 4 Donation 5 Other	n 3 🗆 Rame	oval from State		etery, cremator					10	20c. LO	CATION — C	-		
death. Pag tuneral di Examiner		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENGEE				22. NAME	AND AGORE		CILITY	ONS, I				
rs after deal by the fun removal.		fun	//	NV C		m0095	6 5	130	WISCON	NSIN	AVE	N.W.	WASH	INGT	20016 ON, D.(7.
executed within 24 and completely fill burial, cremation natic event, the	CATION	23. PART I. Enter the dehock, or himmediate cause (Fir disease or condition resulting in death) Sequentially list conditi if any, leading to immecause. Enter UNDERLY! CAUSE (Disease or Inju	dons, dieta	CARDIAC DUE TO CORONAR	C ARRI	CH IINA. EST CONSEQUEN	ce of): DISEA		node of dy		as cen	arec or respi	ratory arm		Approxir interval Onset ar	Betwee
the death certificate be of the attending physician of Mental Hygiene prior to Inlury, or other traun	CERTIFI	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FIND														
signed by Health and ws any in) S	PART II. Other eignifica	nt condition	s contributing to	death bu	t not rasult	ting in tha	underly	ing cause	givan in	Part i.	24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 W	R TO CAUSE
law reclass been Dept. of 23 sh		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH	YES [NO	UNC	ERTAIN	1 🗆				10 100 10	
Cate he State D	SICIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		6. PLACE OF	OTE	ED.								
Sicial certific the S	HYS	1 TYES 2 NO		1 Inpetient 2 I			OA 4 🗆		ome SXXR	aldenca		r (Specify) SCRIBE HOW II	N II IBY OCC	UDEO		
Wer this leath with marked	ВУ Р	2 Accident	Pending Investigation	(Month, D	ay, Year)		INJURY N	1	WORK?	□ NO						
OR ATTENDING PHYSICIAN: The law requibilities and DIRECTOR: After this certificate has been hours after death with the State Dept. of Item 28 is marked, or Item 23 sho	ETED		Could not be determined	26a. PLACE O building,	etc. (Specify	y)	arm, atreet,	factory, of	fica .			ATION (Street a or Town, State)	and Number	or Rural R	oute Number,	
로 로 전 ==	P P			CIAN: To the best of a											and manner as	stated.
TO THE HOSPI TO THE FUNER De filed within) BE	296. SIGNATURE AND TITLE	OF CERTIFIER	Draw	Q.	m				ENSE NUM	IBER		29d. DATE		(Month, Day, Year	
	10	30. NAME AND ADORESS OF GEORGE GRA	VES, M	D 5530	SE OF OEAT	TH (ITEM 27) ONSIN	(Type, Print) AVE.	CHEV			MD.	20815	00.		T, 1990	
		31. DATE FILED (Month, Day, OCT 3	1 1995	32. REGISTRA	TANDIS S'A	Pardal	6									
7				U												

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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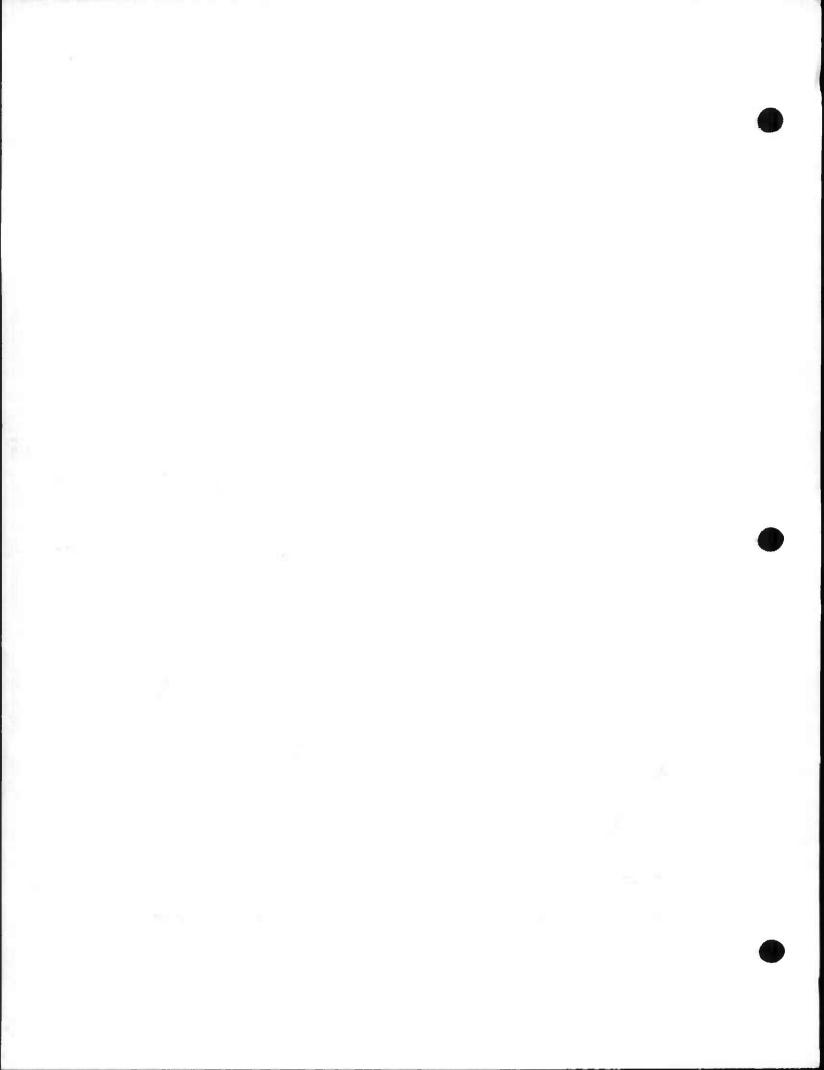
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH NOVEMBER Harriet-Louise Holland Patterson 11-03-1995 1:00 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign IF UNDER 24 HRS. Nov. 21,1903 273-32-4513 1 M 2 ST DAYS HOURS 91 Chicago, Ill Pages 1, 2, 3 should 9a. FACILITY NAIME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9150 Leonardtown Rd. DIRECTOR Hughsville Charles RESIDENCE OF DECEDENT 10e, STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Charles Hughsville 1 YES 2 1 NO permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 9150 Leonardtown Rd. funeral director, page 5 should be detached for use as the burial-transit 20637 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Ordained Minister Clergy 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) Samuel Patterson F Louise Holland BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Kenneth Drummond 9150 Leonardtown Rd. Hughsville, MD 20637 pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must 1 Burlel 2 Cremetton 3 Re 4 Donation 5 Other (Specify) Metropolitan Crem. 11/4/95 Alexandria, VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE AREHART-ECHOL'S FUNERAL HOME, INC. M00945 P.O. Box 567 LaPlata, MD 20646 Down medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or haert feiture. List only one cause on each line. requires that the death certificate be executed within 24 hours afti een signed by the attending physician and completely filled in by to of Health and Mental Hygiene prior to burial, cremation, or remo-Approximata interval Between **IMMEDIATE CAUSE (Finel Onset and Death** the disease or condition resulting in death) OUE TO (OR AS A CONSCOUENCE OF): event, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s, WAS AN AUTOPSY been signed by th 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED¹ any 1 - YES 2 NO 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has b Dept. DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate I HOSPITAL: 1 VES 2 NO 1 Inpatient 2 ER/Outpatie 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATN 26b. TIME OF 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DEȘCRIBE HOW INJURY OCCURED marked, this c 1 Netural 2 Accident 5 Pending 1 YES 2 NO BY After 1 26e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide .00 COMPLETED 8 Could not be DIRECTOR: / 4 Homicide 28 determined Item 1 CERTIFYING PNYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. HDSPITAL E FUNERAL D within 72 ho TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29¢ LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 1995

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia d'Avelson-Randall

32. REGISTRAR'S SIGNATURE



BALTIMORE, MARYLAND 21215-0020

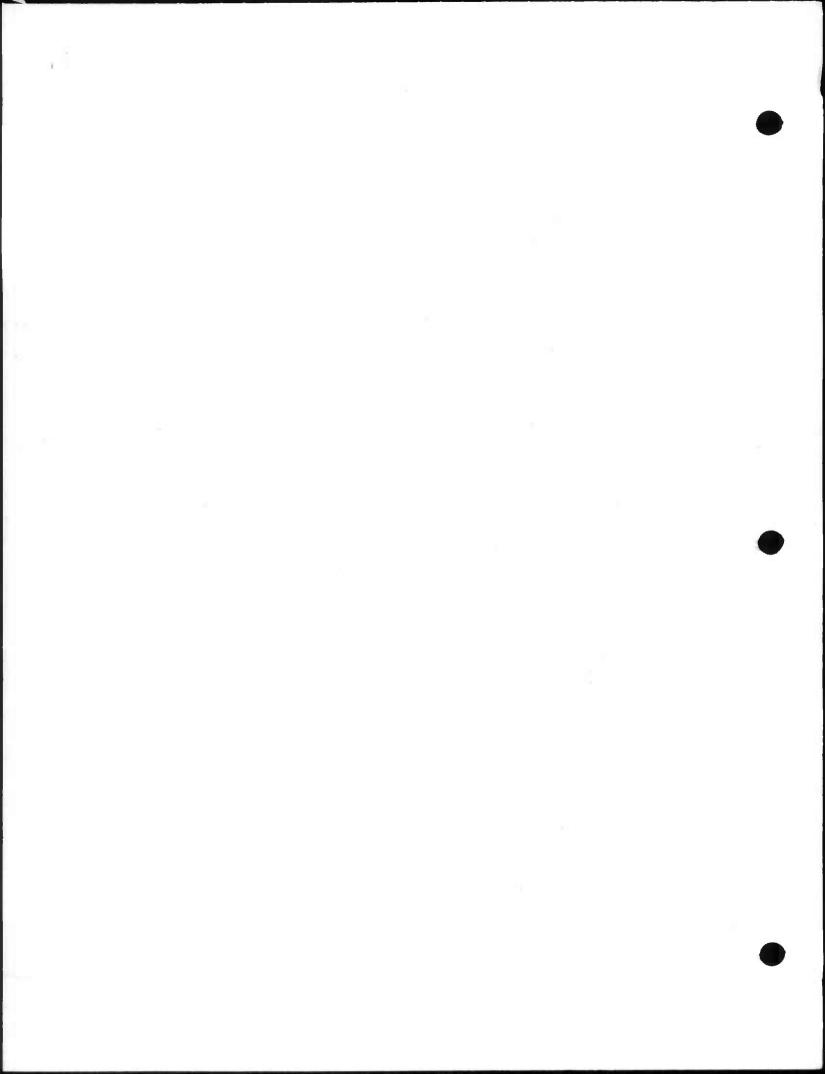
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

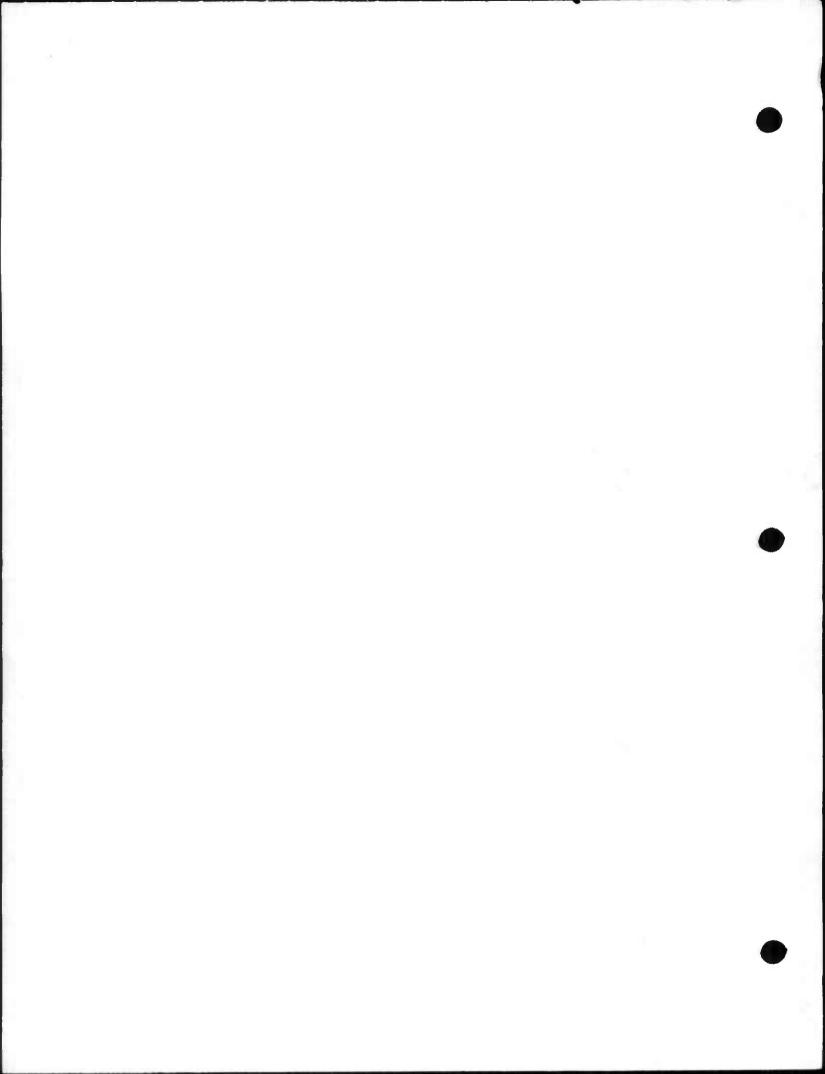
	1 - STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR	TMEN	T OF H	IEALTH AND DEATH	MEN	TAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								ATE OF DEATH			3. TIME OF DEATH
	MARY	В.	PAU	GH						AY	1995	17:10 M
	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. les	st birthday)	IF UNDE	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. D	ATE OF BIRTH forth, Day, Year)			PLACE (State or Foreign
	232-01-1327	1 □ M 2 🏹 F	88	YRS.	MONTHS	DATS	HOURS MIN.	Ma	r 16, 19	907	W	
œ	9e. FACILITY NAME (If not institution, give			_			OR LOCATION OF	DEATH			INTY OF DI	
Ē	MEMORIAL HOSPITAL	& MEDICAL	L CENTE	R	CUM	BERL	AND	ALLEGANY				
DIRECTOR	10e. STATE 10b. COUNT	•		10c. CIT	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY
	WV Mine	eral			Keys	er						1 YES 2 NO
3AL	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	Route 4 Box 299						26726				JSA	
	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT FORCES? 1	YES 2 X			If yes, sp	ENDENT OF HISPA	can, Pue	IGIN? (Specify Yearto Rican, etc.)	e or No—	14. RACE Black	— Americen Indien, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES			1 TYES	2 🕅 NO Spec	elfy:			Specif	y:
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	JCATION	16e. DE	CEDENT'S	USUAL O	CCUPATIO	ON .		16b. KIND OF BU	SINESS/IN		hite
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	se retired.)	ouring mo	st of working					
MP	12			secr	etar	у			Grocer	-	•	
00	17. FATHER'S NAME (First, Middle, Last) B.F. But1								st, Middle, Meiden		-	
BE	19e. INFORMANT'S NAME (Type/Print)	er							M. Smi			
5	Virginia Strickl	er	- 1				nd Number or Rura				p Code)	
	204, METHOD DF DISPOSITION		20b. PLACE				Wester				City or Tox	- Parts
	1 Donetion 5 Other (Specify)	noval from State	Philo	matery or o	ther piecel		me or	1				
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		<i>55</i> 00	22.	NAME AN	ID ADDRESS OF F	ACILITY	/29 We	sterr	port	, MI)
	William H. Fredlock Funeral Home Piedmont, WV 26750											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	shock, or haart failura. IMMEDIATE CAUSE (Final	List only one cause	e on each lina	l.			,,		aratao or rospi	indicity an	1001,	intarval Between Onset and Death
	disease or condition resulting in daath) a. Sepsis								Unknown			
	reading in death)		R AS A CONSEC	DUENCE O	F):							UIIKIIOWII
Z	Sequantially list conditions,	L Advance										Unknown
ATI	If any, leading to immediate		R AS A CONSEC	DUENCE OF	F):							
FIC	CAUSE (Disease or injury that initiated events	c. Hip Fra	CEUTE R AS A CONSEC	DUENCE OF	n:							2 days
CERTIFICATION	reaulting in death) LAST	d			,							<u> </u>
	PART II Other significant condition	no contribution to d	andh bart ar t									
PHYSICIAN: MEDICAL	PART II. Other significant condition	ia contributing to a	eath out not n	eaulting	in tha ur	iderlying	j cauae givan ir	n Part I.	24a, WAS AN PERFOR		246.	WERE AUTOPSY FINOINGS AWAILABLE PRIDR TO
									1 TYES 2	NO		OF DEATH?
Σ	DID TOBACCO USE CONT	DIRLITE TO CALL	SE OF DEA	TLI VE	·	IO F	LINICEDTAL					1 TES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAU		E OF OEAT			UNCERTAI	IN .EX				
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER	R:	5 🗆 Residence	• 🗆 0	thes (Coeffe)			
ξ	27. MANNER OF OEATH	28e. OATE OF IN (Month, Day,	JURY	28b. TIM		28c. INJ	JRY AT		DESCRIBE HOW I	NJURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation	(morari, Day,	1661)	MJ	M	1 🗌 Y	ES 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF I building, etc	NJURY - At hor c. (Specify)	me, ferm, s	streat, fact	ory, office)	28f. L	OCATION (Street e	and Number	or Rural Ro	oute Number,
COMPLETED	4 Homicide determined								,			
AP.		ICIAN: To the best of m										
ő	2 MEDICAL EXAMINE	R: On the basie of exam	mination end/or id	nvestigatio	n, in my o	pinion, de	eath occured at the	e time, d	ate end place, en	d due to th	ne ceuse(e)	end menner as stated.
BE (29h. SIGNATURE AND THE OF CENTIFIE	11					29c. LICENSE NU	мвел		29d. DAT	E SIGNED	Month, Day, Year)
10	Lillin						D 48127	7		Oct	ober	27 1995
	30. NAME AND ADDRESS OF PERSON WA											
	DR. Gregg Wolf	Johnson 32-DECUSTRACE	Heigh	ts Me	edica	al B	ldg. Cur	nber	land, M	D 21	502	
	OCT 31 1995	32 REGISTRAR'S	Who Re	Pal!								
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DIVISION OF VITAL RECORDS, P.O. BOX 88/800	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	TO THE FUNERAL DIRECTOR: After this certificate has been singed by the attending physician and completely filled in by the
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		FOR 1 - STATE REGISTRAR	STATE OF N	IARYLAN	ID / DEPAR CERTIF	RTMENT	OF H	IEALTH A	ND M	ENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last)							-	2. DATE OF DEATH		3.	TIME OF DEATH
		Elizabeth Godf	rey Red	ddish	1				- 1	nesuber	AY	YEAR 1995	5110 A M
		4. SOCIAL SECURITY NUMBER 225-28-1888	5. SEX	6. AGE (In)	rrs. lest birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER 24	HRS.	DATE OF BIRTH	191		ACE (State or Foreign
3 should	_	9a. FACILITY NAME (If not institution, give str						OR LOCATION		н	9c. COU	NTY OF DEAT	
ci .	Š	1312 Irishtow	n Road			North East			t			Cecil	
nit. Pages 1.	DIRECTOR		eci1		10c. CIT	Y, TOWN OR		ton					d, INSIDE CITY LIMITS? YES 2 NO
ansit permit.	FUNERAL	100. STREET AND NUMBER 107 Bridge St	reet				101	219	21		10g. CIT	U.S.	
s the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES :	2 XNO If yes, specify Cuban, Maxic					ORIGIN? (Specify Yer Puarto Rican, etc.)	or No-	14. RACE — Black, W Specify:	American Indian, Thita, atc. White
use as	TED	15. DECEDENT'S EDUC (Specify only highest grade of	completed)		Give kind of life. Do NOT us	work done du	UPATIO	ON asi of working		16b. KIND OF BU	SINESS/INC	DUSTRY	
page 5 should be detached for the notified at once.	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Produc		L	ine		Plas	tico	oid C	orp.
at once.		17. FATHER'S NAME (First, Middle, Last) Charles F. By:	17. FATHER'S NAME (First, Middle, Last)					2010/10/20		(First, Middle, Maiden			
notified	BE	19a. INFORMANT'S NAME (Type/Print)	Lu		19b. MAILING	ADDRESS (Street a			hine E.			
be not	5	John B. Reddis	sh										d. 21901
must		20a. METHOD OF DISPOSITION 1/a Burlal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)		20b. PL cemeter A 1	ACEAND DATE Ty, cremetory or o	OF DISPOSIT	ON /No	me of		OATE 20c. LO	CATION —	City or Town,	State
or removal. medical examiner		22. NAME AND ADDRESS OF FACILITY 259 E. Main St., Gee Funeral Home Elkton, Md. 2192											
shows any injury, or other traumatic event, the medic	CERTIFICATION	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ineast failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF):											
of Health and Meni	MEDICAL	1 Tyes 2 10 OF								RE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO			
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death with the	Y PHYSICIAN:	27. MANNER OF DEATH 1 Pantural 5 Pending	26a. DATE OF I	NJURY	26b. TIM	E OF 20	ic. INJU	URY AT	20	d. DESCRIBE HOW I	NJURY OC	CURED	
after d	ЕТЕО ВУ	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF building, e	INJURY — i tc. (Specify)	At home, farm, s				-	If. LOCATION (Street a City or Town, State)	and Number	or Rural Route	Number,
ANT: If Item	COMPL	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER											d manner as stated.
be filed within 7.	BE	296. SIGNATURE AND TITLE OF CERTIFIER	D					DI 5			29d. DATE	SIGNED (MO	nth, Day, Year)
	10	30. NAME AND ADDRESS OF PERSON WHO HFar Kas, MD	COMPLETED CAUSE	of OEATH	(ITEM 27) (Type,	Print) he H	CA.	'ce p	Ikto	=39 5, mp 2,	Pridg	e st.	4 , 1995
		OCT 24 1995	32. REGISTRAR	SIGNATURAL ROM	RE COLL	,,,	11.	, 0	, ,		, , ,		



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funeral director, page 5 should

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27. MANNER OF DEATH

1 🔯 Natural

2 Accident

4 Homicide

29a, CERTIFIER

3 🗌 Sulcide

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or re	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the med

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 **BERTHA** Marjorie RUSSELL NOVEMBER 25 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig DAYS 217-74-0059 1 M 2 X F 75 VRS May 1, Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Mary's St. Mary's Hospital Leonardtown RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland St. Mary's Mechanicsville 1 YES 2 T NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3605 Three Notch Road 20659 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes of No- RACE — American Indian, Black, White, atc. 1 Never Merried 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: BY Specify: White 3 🛛 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumerne) Lee, Sr. Edward Newton Myrtle Marie Curry BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 5175 Queentree Road, Mechanicsville, Maryland 20659 Helen L. Long 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, State Zion United Methodist Cemetery 11/11/95 Mechanicsville, Maryland 4 Donation 8 Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, Approximata shock, or heart fellure. List only one cause on each line interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition ara non 4/95 resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions. EQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 TO NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL 1 TES 2 NO

OTHER: Sympatient 2 ER/Outpatient 3 DOA

4 Nursing Home 5 Residence 8 Other (Specify) 28d. OESCRIBE HOW INJURY OCCURED

28c. INJURY AT 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29c LICENSE NUMBER

15

36

1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Parti

Shanti Medical Center, Leonardtown, MD

32. REGISTRAR'S SIGNATURE

28a. DATE OF INJURY (Month, Day, Year)

31. DATE FILED (Month, Day, Year) NOV 09 1995

5 Pending

29b. SIGNATURE AND TITLE OF CENTIFIER

Umed K. Shah, M.D.

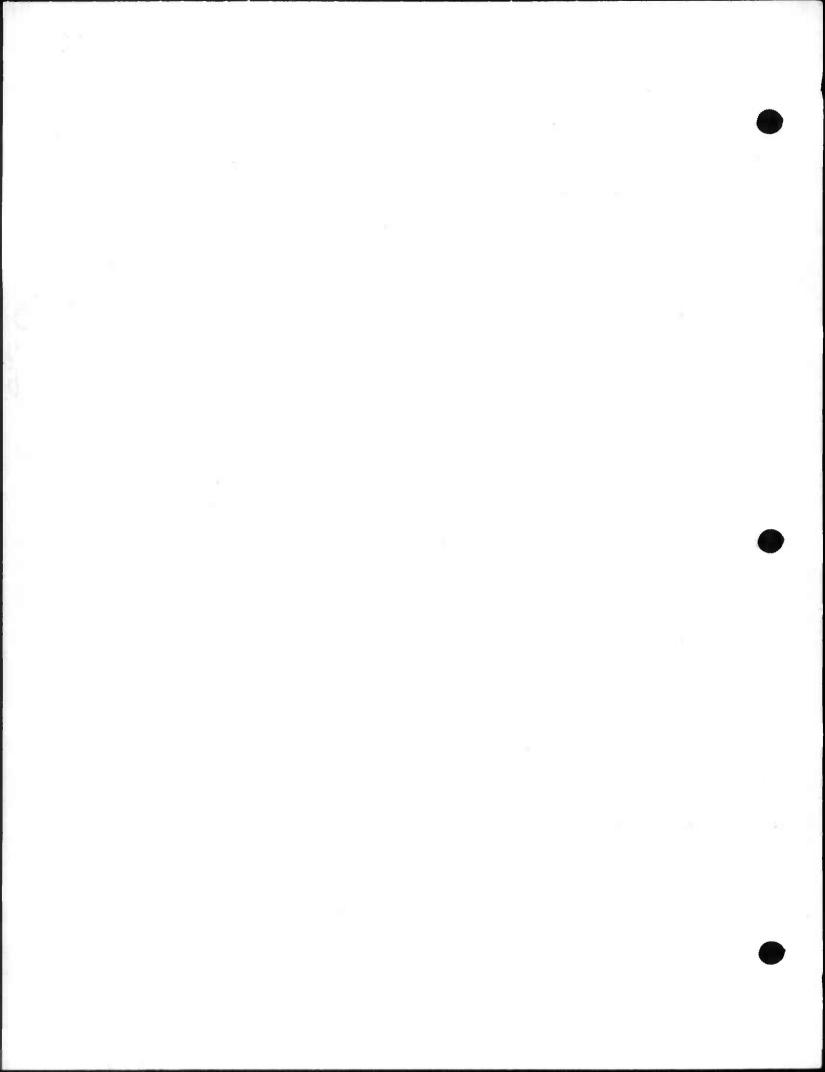
8 Could not be

determined

DHMH-18 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

11



exec	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State heart and Mental Horiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL	THE FUNERAL	MPORTANT: II

FOR STATE REGISTRAR	STATE OF MARY	CERTIF	ICATE O	FDEATH		REG. NO.				
	HUNT ROBERTS				OC	CT 28		YEAR	3. TIME OF DEATH A	
4. SOCIAL SECURITY NUMBER 212-76-1630	1 □ M 2 X F = {	E (in yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS	1	(Monti	5, 19		Flo:	rida	
90. FACILITY NAME (If not institution, gh NATIONAL NAVAL	MEDICAL CENT	TER .	-	R TOWN OR LOCATION OF DEATH BETHESDA				9c. COUNTY OF DEATH MONTGOMERY		
mesidence of decedent 10e. STATE 10b. COU Maryland Mor			TY, TOWN OR LOC					10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
10e. STREET AND NUMBER	-37			101. ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?	
10500 Rockville	Pike #915			20852			Uni		States	
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, OIVE WAR OR	S 2X NO If yes, specify Cuben, Mexican			in, Puerlo Rican, etc.)			Biac	RACE — American Indien, Black, White, etc. Specify: White	
15. DECEDENT'S E (Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4 or 5+)	(Give kind of life. Do NOT L	T. C. C. C.			. KIND OF BUS		DUSTRY		
	2	Housewi	.fe	1		Own Ho				
17. FATHER'S NAME (First, Middle, Last) William	Н.	Hun	ıt	16. MOTHER'S NA	AME (First, I	Middle, Malden	Surname)		Jenkins	
19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	O ADDRESS (Street	at end Number or Rural	Route Num		n, State, Zip	p Code)		
Judson L. Robert	son III	9216	Scott D	r., Rockv	ille		2085			
20e. METHOD OF DISPOSITION 1	emoval from State	cometery, crematory or U.S.U.H.	of Disposition other place)	(Name of	10-3	E 20c. LO Betl			Own, State	
							_			
21. SIGNATURE OF FUNERAL SERVICE	elet	M00827	Rapp 933	Funeral Gist Ave,	Serv Sil	ver Sp	ring		20910	
23 PANT I. Enter the diseases,	or complications that cause re. List only one cause on CONGE	sed the death. Do n each line. ESTIVE HE	Rapp 933 not enter the	Funeral Gist Ave,	Serv Sil	ver Sp	ring		20910 Approximate Interval Betwee Onset end Da 14 Mo 1 s	
23 PART I. Enter the diseases, shock, or heert fellu IMMEDIATE CAUSE (Finel disease or condition resulting in death)	or complications that couse on List only one couse on CONGI	sed the death. Do n each line.	Rapp 933 not enter the r CART FAI	Funeral Gist Ave, mode of dylng, suc	Serv Sil	ver Sp	ring		Approximate Interval Betwee Onset end De	
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DIVISION OF VITAL RECORDS, P.O. BOX 6876	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 la	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fille	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the
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STATE REGISTRAFI CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 505A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDERGIA HIS 6. BIRTHPLACE (State or Foreign 578-54-6611 1 M 2 XX 84 9,1911 JANUARY MASSACHUSETTS 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY FLORIDA BROWARD HOLLYWOOD 1X YES 2 □ NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE 2300 PARK LANE UNITED STATES 33021 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 — YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: WHITE BY 3 🗓 Widowed 4 🗌 Divorced 16a. DECEDENT'S USUAL OCCUPATION ED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MEYER LERNER MOLLIE LONDON 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARLENE BERMAN 912 HYDE ROAD - SILVER SPRING, MARYLAND 20902 20a METHOD OF DU 1 XBurial 2 SITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata 3 🗆 R CING DAVID MEMORIAL GARDEN 10/27 4 Donation FALLS CHURCH, VA. ther (Specify) NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 23. PART I, Enter the disc or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, ahock, or hear to lura. List only ona cause on each line. Interval Batween Onsat and Death IMMEDIATE CAUSE (Finel disease or condition_ STROKE reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): 57000515 CAROTIO CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If eny, laading to immediata cause. Entar UNDERLYING 255 ATHEROSCLEX CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) HOSPITAL: 1 Impatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/pr investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated, 29d. DATE SIGNED (Month, Day, Year) BE 16. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W15C. NE. 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) 30 1995

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DHMH-16 Rev 1/89

funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

the attending physician and completely filled in by the it Mental Hygiene prior to bunal, cremation, or removal.

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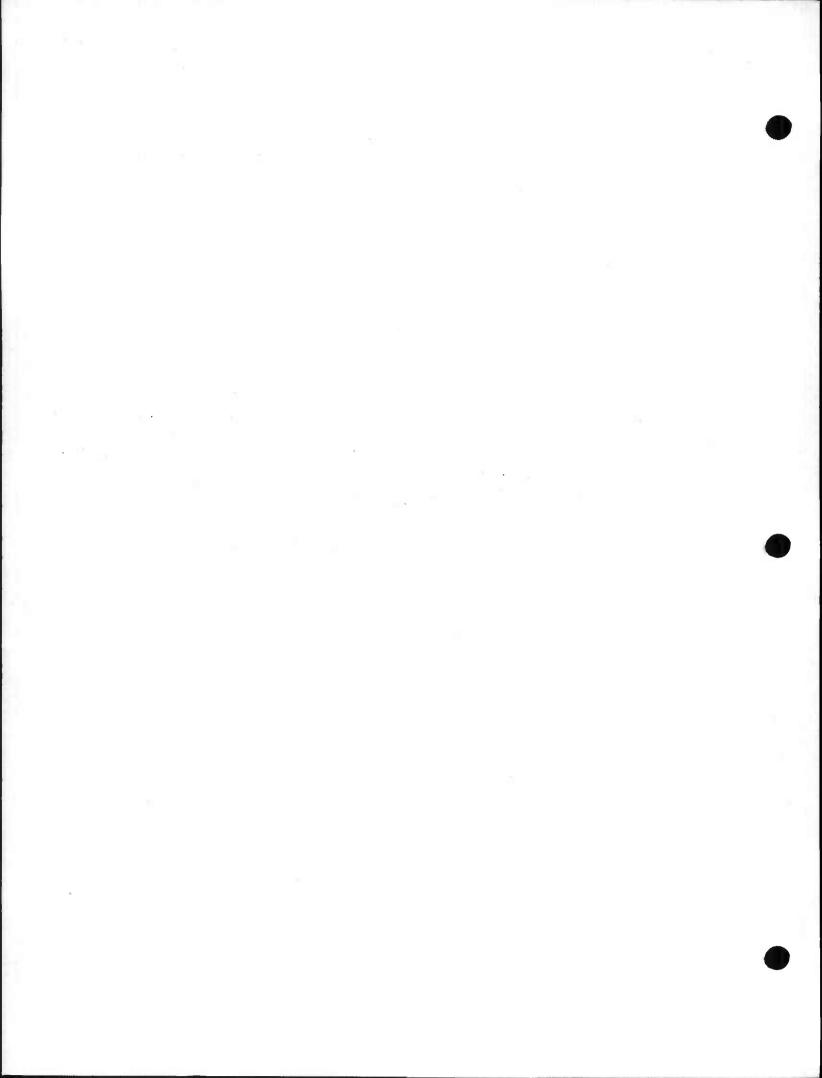
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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS. P.O. BOX 6876

FOR STATE REGISTRAFI STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 October 31, CARL LINDEN ROLLINSON 5:00 Рм 4. SOCIAL SECURITY NUMBER 8. AGE (in vrs. last birthday 7. DATE OF BIRTH IF UNDER 1 YEAR IF LINDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 X M 2 F 326-14-9983 86 Feb. 25, 1909 New York 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR 112 Piping Rock Drive Silver Spring Montgomery RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 XYES 2 NO FUNERAL 10a STREET AND NUMBER 101. ZIP CODE 20905 112 Piping Rock Drive United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: BY 3 🗓 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondery (0-12) College (1-4 or 5 +) Chemistry Professor Emeritus of 12 5+ Education 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at Ralph Rollinson Gladys Gauger notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 Kathleen Ann Rodkey Timber Ridge Drive, Silver Spring, MD 20905 pe 20e. METHOD OF DISPOSITION
1 □ Burlel 2 1 Cremation 3 □ Removal from State
4 □ Denationy 5 □ Other (Specify) 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Fort Lincoln Crematory Brentwood, Maryland examiner 21. SHOWATURE OF FUNERAL SERVICE DICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heert feliure. List only one ceuse on each line. intervai Batween Onset and Death **IMMEDIATE CAUSE (Final** the diseese or condition estino PNO event. resulting in death) DUE TO (OR AS CONSEQUENCE OF) traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN 🛣 PHYSICIAN: 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL item EXAMINER? OTHER: 1 YES 2 NO 1 Inpatient 2 SEER/Outpatient 3 I DOA ng Home 5 🕅 Realdanca 8 🗆 Other (Specify) the or 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Matural 5 Pending Investigation 1 YES 2 NO 10.31.95 BY Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 8 Could not be DIRECTOR: A hours after ditem 28 is COMPLETED 4 Homicide TO THE HOSPITAL OR ATTR TO THE FUNERAL DIRECTO be filed within 72 hours af IMPORTANT: If Item 21 1 SCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(a) and manner as stated. 2 🗋 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) H M.D hay D39671 NOVEMBER 1 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11119 ROULVILLE 31. DATE FILED (Month, Day, Year) 32. BEGISTRAR'S SIGNATURE 03 1995 Julia Davidson Rardall



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital on a signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notitled at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

Amended #1, 10/31/95, MRT, Montgomery County

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
(RAR) CERTIFICATE OF DEATH REG. NO.

1 - STATE REGISTRAR		CERTIFI	CATE O	F DEATH	REG. NO	D.		
1. OECEDENT'S NAME (First, Middle, Last)					2. OATE OF OEATH MONTH	DAY	YEAR	3. TIME OF DEATH
Eugene J.	Rogers	Rodger	S		Oct. 30	, 199	95	12:05 a. w
		n yrs. lest birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH	1000	6. BIRTH	PLACE (State or Foreign
1 223-10-43U3	⊠ M 2 □ F 95	YRS.	MONTHS DAYS	HOURS MIN.	OCT 28	T900	5.	"Carolina
9a. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COU	NTY OF D	EATH
Kensington Garde	ns Rehab	Center	Ker	sington		MO	NTG	OMERY
10a. STATE 10b. COUNTY			, TOWN OR LOC					10d. INSIDE CITY LIMITS?
Maryland Monte	gomery		Bethe	sda				1 X YES 2 NO
100. STREET AND NUMBER 4521 East West	t Highway	Apt# 8		20815			J.S.	WHAT COUNTRY? A.
	. WAS DECEDENT EVER IN FORCES? 1 X YES		13. WAS D	ECENDENT OF HISPAN	IIC ORIGIN? (Specify Y	aa or No	14. RACI	- American Indian, k, White, etc.
1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA			specify Cuban, Maxica ES 2 7 NO Specify				ack
15. DECEDENT'S EDUCATI (Specify only highest grade com	iON npleted)	16a. DECEDENT'S	USUAL OCCUPA	TION	18b. KINO OF B	USINESS/IN	DUSTRY	
Elementary/Secondary (0-12) C	College (1-4 or 5+)	tife. Do NOT us	e retired.)		01	ll S∈	~~~i	00
	Yrs	Ceme	nt Fil	nisher			-T A T	<u> </u>
17. FATHER'S NAME (First, Middle, Last) Emmanuel Re	odgers			18. MOTHER'S NA	ME (First, Middle, Maide ah ?	en Sumame)		
19a. INFORMANT'S NAME (Type/Print)	(Wife)	19b. MAILING	ADDRESS (Street	t and Number or Rural	Goute Number, City or To	wn, State, Zi	p Code)	
	dgers		***					
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		. PLACE AND DATE Of the lettery, crematory or of WOOdlaw				b Be.		wn, Stata r, Va
21. SIGNATURE OF FUNERAL SERVICE LICENS		/			IERAL HO			
Frank R	Myw	Ken		WDEN FUN			₽.A.	
23. PART I. Enter the diseasee, or con	plicatione that caused	the death. Do n	ot enter the r	node of dylng, auc	h aa cardiac or res	piratory as	rest,	Approximate
ahock, or haart failura. Liat	only ona cause on ea	acn IIna.						Interval Between Onsat and Death
disease or condition resulting in death)	Multiple	Cereb	ral In	farction	ns			months
	Cerebrov							years
Sequentially liat conditiona, if any, leading to immediata	DUE TO (OR AS A	CONSEQUENCE OF	7):					
cause. Entar UNDERLYING CAUSE (Disease or Injury								
that initiated events reaulting in daath) LAST	DUE TO (OR AS A	CONSEQUENCE OF	÷):					
d								
PART II. Other eignificant conditions of	ontributing to death b	ut not rasuiting i	n tha undarly	ing cause given in	Part I. 24a. WAS /	N AUTOPSY	246	. WERE AUTOPSY FINDINGS
Multi-infarct	dementia:	cache	xia: a	spiratio	on perf	ORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
						- 65110		DF DEATH?
DID TOBACCO USE CONTRIB	SUTE TO CAUSE O	F DEATH YE	S NO	UNCERTAI	12xN			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT		10)				
The state of the s	OSPITAL: Inpetient 2 ER/Outp	patient 3 🗆 DOA	OTHER: 4X Nursing H	oma 5 🗆 Raaldence	6 Other (Specify)			
27. MANNER OF OEATH	28e. OATE OF INJURY (Month, Day, Yeer)	28b. TIMI	E OF 28c.	NJURY AT WORK?	28d. OEŞCRIBE HOV	INJURY O	CUREO	
1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
3 Suicide a Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, a	streat, factory, o	ffice	28f. LOCATION (Stree City or Town, Ste		er or Rural	Route Number,
29e. CERTIFIER WYCERTIEVING PHYSICIA	N: To the best of my land	Jadas daret	4 4 4 4 4	an manner of the				
(Check only one) 2 MEDICAL EXAMINER: (a) and manner as ataled.
29b. SIGNATURE AND TITLE OF CERTIFIER	16.			29c. LICENSE NU	MBER	29d. OA	TE STONE	(Month, Day, Year)
Martin C /2	and W			D 089	44		0 30	0 195
Martin C. Sharge	/)			at Ave.,	Kensing	ton,	MD	20895
31. DATE FILEO (Month, Day, Year)	32. REGISTRAN'S SIGN	MURE						

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
日五	TO THE	IMPO

	1 - FOR STATE REGISTRAR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH		3. TIME OF DEATH	
	Paul	Harry Robinson				Oct. 28, 1995 7:00 p. M			
	4. SOCIAL SECURITY NUMBER	1,41102		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Count	HPLACE (State or Foreign	
BY FUNERAL DIRECTOR	217-18-1884 1 🖾 M 2 🗆 F 72		YRS.	9b. CITY, TOWN OR LOCATION OF DEATH		Apr.8,19	1923 Maryland		
					er Spring MONTGOMERY				
	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE					10d. INSIDE CITY			
	Maryland Montgomery			Gaithersburg			LIMITS?		
	10e. STREET AND NUMBER			10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
	12318 Fellowship Way			20878			U.S.A.		
	11. MARITAL STATUS 1 □ Naver Married 2 □ Married 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 ☒ YES 2 □		2 NO	NO If yes, specify Cuben, Mexican, F		, Puerto Rican, etc.)			
	3 X Widowed 6 Divorced IF YES, GIVE WAR OR DATES			1 ☐ YES 2 💢 NO Specify:			specify: Black		
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give ki			EDENT'S USUAL OCCUPATION IGNORATION IN MORE BUT IN MOR			JSINESS/INDUSTRY		
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)			nipping Clerk			Lumber Company		
MP	17. FATHER'S NAME (First, Middle, Last)								
	Charles E. Robinson			1a. MOTHER'S NAME (First, Middle, Maide Laura Jones			i Surneme)		
BE (ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
5	Freddie Robinson (Son) 412 Navahoe Drive, Frederick, MD 21701								
	20e. METHOD OF DISPOSITION 17℃ Burlel 2 ☐ Cremetion 3 ☐ Remo	20b. F cemg	PLACE AND DATE OF	DISPOSITION (Na or place)	me of		CATION — City or To		
	Secretary 11/3 Poolesville, MD 11/3 Poolesville, MD 22. NAME AND ADDRESS OF FACILITY								
	SNOWDEN FUNERAL HOME, P.A.								
	21 FAHT i. Enter the diseases, or c	abunications that caused	the deeth. Do no		XVILLE.			Approximate	
	ahock, of heart failure. I	Liat only one cause on aac	ch line.			ilwe		interval Between Onset and Death	
AL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PREFORMED? 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO								
200	That f. stulas 1 - YES 2 THO COMPLETION OF CAUSE OF DEATH?								
. ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
AN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)								
SIC	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Variang Home 5 Residence 8 Other (Specify)								
TED BY PHYSICIAN: MEDIC	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJ		28d. DESCRIBE HOW II	NJURY OCCURED		
	2 Accident			home, ferm, street, fectory, office 28f		8f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET	29a. CERTIFIER (Check only) CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(a) and menner as stated.								
NO.	one) 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.								
BE	296. SIGNATURE HAID TITLE OF CENTIFICH 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)								
6	30. NAME AND ADDIESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	12016 Georgia Ave Whoaton, no 20902 M-Wajeed Khan								
	31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE								
	OCT 31 1995	Hurr animary.	a the day						

e audit es

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS DO BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and lead to fine a manage of may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	THE CHILD'S IN THE CAST THE CAST OF THE CA	IMPORTANT if item 28 is marked or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any normal regions that hospital or attending physician.	DIVISION OF VITAL RECORDS, P.O. BOX 88780, BALLIMORE, MARYLAND 21215-0020
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N CERTIFICATE OF DEATH		YGIENE REG. NO.
4	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF I	DEATH DAY
ı	MARTAN LETCH DUSSE	יד.ד	10	24

3	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DE. MONTH	ATH DAY	VE	AR	3. TIME OF DEATH	
	MARIAN LEIGH RUSSELL						10	24			1440	М
8	4. SOCIAL SECURITY NUMBER 5. SEX		s. last birthday)	IF UNDER t Y		INDER 24 HRS.	7. DATE OF BIR (Month, Day,	TH Year)	8.1	BIRTHE	PLACE (State or Foreign	,
- 8	215-26-7289 1 D M 2	X 0 F	79 YRS.	MONTHS D	AYS HOU	IRS MIN.	01-17-			Journey	MD.	
	9a. FACILITY NAME (If not institution, give street and num	ber)		96. CITY, TO	WN OR LO	CATION OF DE			9c. COUNTY	OF DE		
DIRECTOR	411 WICOMICO STREET			SALIS	BURY				WICOM:	ICO)	
E I	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR L	OCATION					T	10d. INSIDE CITY	
	MD. WICOMICO		S	ALISE	URY						LIMITS? 1 XYES 2 NO	
Z	10e. STREET AND NUMBER				10f. ZIP	CODE			10g. CITIZEN	OF W	HAT COUNTRY?	
	411 WICOMICO STRE	ET			21	1801			U.	S.	Α.	
FUNERAL	11. MARITAL STATUS 1 X Never Married 2 Married FORCE	S? 1 YES 2	ARMED V NO	13. WAS	DECENDE	NT OF HISPAN Cuben, Mexica	IC ORIGIN? (Spen	offy Yan o	or No 14.		- American Indian, White, alc.	
В	3 Widowed 4 Divorced	GIVE WAR OR DATES	, A			NO Specify		,		Specifi		
	15. DECEDENT'S EDUCATION			1							WHITE	
ш	(Specify only highest grade completed)		(Give kind of w life. Do NOT use	rork done duri	PATION ng most of w	vorking	166. KIND	OF BUSI	NESS/INDUST	HY		
COMPLETED	Elementary/Secondary (0-12) College (1	4 or 5+)	DENT		CTC	ANT	_ n	ENT	AT			
Ē			DENIA	AL AS								
	17. FATHER'S NAME (First, Middle, Last)				18.		ME (First, Middle,					
מ	JOHN TYNAN RUSSE	LL					LOUIS					
2	19a. INFORMANT'S NAME (Type/Print)		196. MAILING	AOORESS (S	treet and Nu	imber or Rural F	loute Number, City	or Town,	State, Zip Coo	de)		
	BONNIE RUSSELL		321	HALI	PLA	ACE, I	MILFOR	D,	DELAW	AR	E 19963	
	20a. METHOD OF DISPOSITION 1 Name 2 Cremation 3 Removal from S		ACE AND DATE O		Neme of		OATE 2	20c. LOC	ATION — City	or Tov	vn, Stata	
	4 Donation 5 Other (Specify)		RSONS	CEME	TERY	(10/28	SA	LISBU	JRY	,MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAI	ME AND AD	DRESS OF FAC	CILITY					
	* Quald C/2	rund		Воц	NDS	FUNE	RAL HO	ME,	SALIS	BU	RY, MD.	
П	23. PART i. Enter the diseases, or complication shock, or heart failure. List only of	ns that caused the	e death. Do n	ot enter the	mode of	dying, such	as cardiac o	respin	atory arrest,		Approximate	
	IMMEDIATE CAUSE (Final	ne cause on each	line.								Onset and De	
	disease or condition	RIOSCLERO	איידר כא	VOTOU	A COTIT	אם חדכ	ENCE				MEADC	
1		DUE TO (OR AS A CO			HOCUL	WK DIS	CASE				YEARS	_
z												
CEMILLICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	NSEOUENCE OF):								
3	cause. Enter UNDERLYING											
	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF):							1	
	resulting in death) LAST											
MEDICAL	PART ii. Other significant conditions contribute	ting to death but r	not resulting in	n the unde	riying cau	ise given in	Part I. 24a. V	NAS AN A			WERE AUTOPSY FINDIN AVAILABLE PRIOR TO	IGS
3							1	YES 2	Хио		COMPLETION OF CAUSE OF DEATH?	E
L L											1 YES 2 NO	
- 1	DID TOBACCO USE CONTRI	BUTE TO CA	AUSE OF	DEATH	YES	☐ NO						
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				6. PLACE	OF DEATH (Che	ck only one)					
7	HOSPIT.	AL: int 2 - ER/Outpaties	nt 3 🗆 DOA	OTHER:	Home 5	XResidence	6 Other (Speci	ffy)				
PHTSICIAN:	7.7	ATE OF INJURY	26b. TIME	OF 28	c. INJURY A	Y	26d. OESCRIBE	-	JURY OCCUR	ED		_
	1 (2) Natural 5 Pending	fonth, Day, Year)	INJU		WORK?	2 NO						
10	3 Suicide e Could and by 28e. P	LACE OF INJURY -	At home, ferm, s	treet, factory.	offica		26f. LOCATION	(Street an	d Number or R	tural Ad	oute Number,	
1	4 Homicide determined	ullding, atc. (Specify)				i	City or Town	, State)				
	29a. CERTIFIER			V/28-12-22								_
COMPLEIED	(Check only one) 1 CERTIFYING PHYSICIAN: To the											
3	one) 2 MEDICAL EXAMINER: On the ba	all of examination en	G/O/ Investigation	n, in my opin	lon, desth (occured at the	time, data and pi	aca, and	dua to tha ca	use(a)	and manner as stated	1.
u l	29b. SIGNATURE AND TITLE OF CERTIFIER		_		29c.	LICENSE NUM	BER	\Box	29d. DATE SIG	GNED	(Month, Day, Year)	
	John G G Jul	brelay .	n. D.	M.E.	DO	3599			▶10-2	4_9	95	
2	30. NAME AND AGORESS OF PERSON WHO COMPLETE	ED CAUSE OF DEATH	(ITEM 27) (Type,	Print)					10.2			
	JOHN T. BULKELEY, M.D.,	108 PINE	चनाराह	BOYD	CAT	TCRIDV	MADUT	רוזאא	21001			
	31. DATE FILEO (Morith, Day, Year) 32 RE	GISTRAR'S SIGNATUR	DE	NUAD	CAL	TODUK Y	/_MARYI	AND	21801	_		
	OCT 26 1995 July	Davidson 1	Cardall									
_	7											

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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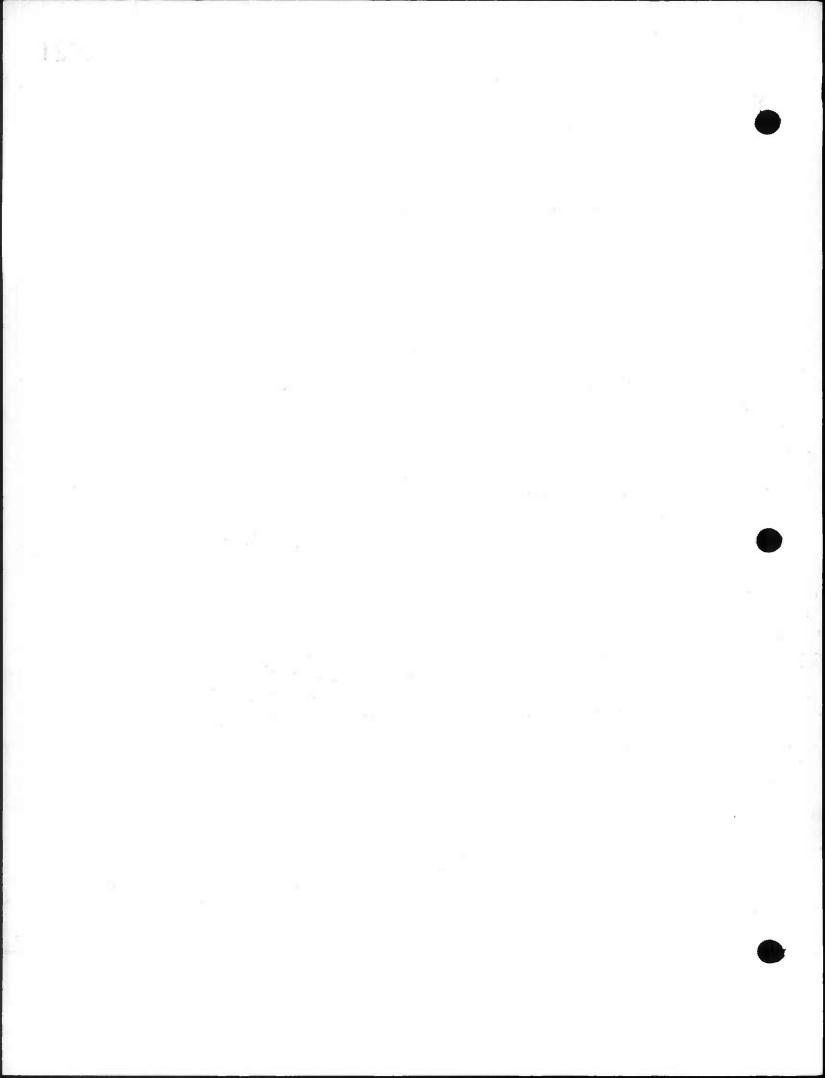
	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	ADV LOUTEE	JONEC	0		2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH
		ARY LOUISE .		ROBE	7	OCTUBER	21,1991	2130 H
	044 00 4770	5. SEX 6. AGE ((In yrs. last birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	MALLER CO. M. A	5 DEA	HPLACE (State or Foreign try) L'ISLAND, MD
<u>~</u>	90. FACILITY NAME (If not institution, give size PENINSULA REGIO		CENTER		OR LOCATION OF		9c. COUNTY OF D	DEATH
E	RESIDENCE OF DECEDENT							
DIRECTOR	MD. WICO	MICO		Y, TOWN OR LOCAL	TION			10d. INSIDE CITY LIMITS?
FUNERAL	10e. STREET AND NUMBER	O HOME BOO:		10	H. ZIP CODE		10g. CITIZEN OF	1 🖄 YES 2 🗌 NO WHAT COUNTRY?
Ä	WICOMICO NURSINO				2180		USA	
B	1 Never Mented 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO	If yes, s	CENDENT OF HISP pecify Cuben, Mexi 3 2/ NO Spe	PANIC ORIGIN? (Specify Yes Ican, Puerto Rican, etc.) Icify:	s or No— 14. RAC Blac Spec	E — American Indian, ik, White, etc. BLACK
ED	15. DECEDENT'S EDUCA (Specify only highest grade of	iTION ompleted)	16a. DECEDENT'S	USUAL OCCUPATI	ON of wadden	16b. KIND OF BUS	SINESS/INDUSTRY	
COMPLET	Elementary(Siecondary (0-12)	College (1-4 or 5+)	SELF-EMF	se retired.)		NG. SEAMS	TERESS	
NO.	17. FATHER'S NAME (First, Middle, Last)				_	NAME (First, Middle, Melden		
BE (HAMILITON 3				EMMA WILI		
10	190. INFORMANT'S NAME (Typo/Print) ROMAINE PARKER		19b. MAILING	COOK DRI	VE: SAL	ISBURY, MD.	n, Stefe, Zip Code) 21801	
	20a. METHOD OF DISPOSITION 1. Buriel 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	al from State Cen	PLACE AND DATE	OF DISPOSITION (N	ame of H. CEM.	DATE 20c. LO 10-27 DE/	CATION — City or TO	
	21. SIGNATURE OF FUNERAL SERVICE LICE					FACILITY JOLLEY	MEMORIAL	OHADEL
- 93	→			1213	JERSEY F	ROAD, SALISE	BURY, MD.	21801
CERTIFICATION	23. PART I. Enter the diseases, or co shock, or heeft feliure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	Aspare Due to jor as a	consequence of	- Pu		uch as cerdiac or reapi		Approximate Interval Between Onset and Death
Ö	PART II. Other significant conditions	contributing to death b	ut not resulting	in the underlyin	a cerree alven	In Pert I. 24a, WAS AN	Aurmony I am	. WERE AUTOPSY FINDINGS
MEDICA	Coma	= , As	eteri		erasi	PERFOR	MED?	AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
ME	DID TORACCO LIST CONTRI	DUTE TO CALICE O	E DEATH W	·		<u> </u>		1 YES 2 NO
AN	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA		UNCERTA	IN L		
Sic		HOSPITAL:	atient 3 🗆 ODA	OTHER:	te 5 🗆 Residenc	e 8 Other (Specify)		
BY PHYSICIAN:	27. MANNER OF SEATH 1	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	PURY AT ORK? YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCUREO	
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, ferm, :	street, factory, offic	•	281. LOCATION (Street a City or Town, State)	nd Number or Rural I	Route Number,
COMPLETED		AN: To the best of my knowl						
	29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of examination	end/or Investigatio	n, in my opinion, d	leath occured at the		d due to the ceuse(e	
TO BE	(wageg	ofc 1	un		17370	670	10/	22/95
	30. NAME AND ADDRESS OF PERSON WHO	ang Eli	ate (ITEM 27) (Type	100	3 Por	Lung.	uff	id #4
	31. DATE FILED (MONTH, Day, Year) OCT 26 1995	32. REGISTRAR'S SIGNA	ATURE OF Rawfall	4		8	75017	1
		-						

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /		OF HEALTH AND A	MENTAL HYGIENI REG. NO.	=	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	CATHERINE MARIE	ReMAY			November 2		1:05 P M
	and the state of t	. SEX 6. AGE (In yrs. lest			7 DATE OF BIRTH		HPLACE (State or Foreign
	529-12-4548 1 9. FACILITY NAME (If not institution, give street	□ M 2 (X) F 74	YRS.				Utah
œ	St Mary's Nursing			TOWN OR LOCATION OF DE	ATH	9c. COUNTY OF D	
DIRECTOR	RESIDENCE OF DECEDENT	center	Leor	nardtown		ST MARY	.2
R	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR				10d. INSIDE CITY LIMITS?
	Maryland St Mar	y's	Charlot				1 X YES 2 □ NO
FUNERAL	Route 2 Box 178			101. ZIP CODE 20622		10g. CITIZEN OF T	WHAT COUNTRY?
3		12, WAS DECEDENT EVER IN U.S. ARMED 13, WAS DECEMBENT OF HISPANIC ORIGINS (Specify Yea or No. 14)					E — American Indian,
BY F	1 Never Married 2 Merried 3 N Widowed 4 Divorced	FORCES? 1 YES 2 NO) If	yes, specify Cuben, Mexicar YES 2 NO Specify	n, Puerlo Rican, etc.)	Blac	k, White, etc.
							White
E	15. DECEDENT'S EDUCATI (Specify only highest grade con	npleted) (Giv	EDENT'S USUAL OCC s kind of work done du Do NOT use retired.)		16b. KIND OF BUS	INESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12) 0	College (1-4 or 5 +)	usewife		Own	Home	
OM	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAM	ME (First, Middle, Melden S		
BE C	Frederick W. Roeli	ng		Cat	herine Rot	h Roelin	g
TO B	19e. INFORMANT'S NAME (Type/Print)			Street and Number or Rural R			
-	John R. Howell	Rc	ute 2 Bo	x 178 Charl			
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal	I from State 20b. PLACE AI cernetery, crem	ID DATE OF DISPOSIT atory or other place)	al Gardens	DATE 20c. LOC	CATION — City or To	own, State
	4 Donation 5 Donat (Specify) May	<u>soleum rinit</u> see	y Memori	al Gardens	11-4-95 Wa	Idort, M	iD
	11 // 451 4			B55 Holy La		1 d = 10 € 10	10.0001
	23. PADVI. Enter the diseesea, or com	Sewen Moc		-			
	ahock, or haert fellure. List	t only one ceuse en each lina.	1 1				Approximate Interval Between
1	IMMEDIATE CAUSE (Final disease or condition	Inela	11/	sailor	Acen	M	Onset and Death
	reaulting in death)	DUE TO (OR AS A CONSEQU	-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11001	_	172
z							1
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate	DUE TO (Off AS A CONSEQU	SENCE OF):				
2	CAUSE (Disease or injury	DUE TO JOR AS A CONSEQU	TENOT DEL				
Ē	that initieted events resulting in death) LAST	DUE TO JOH AS A CONSECU	HENCE UP):				1
	-1	11	/	1			
AL	PART II. Other algoriticant abnditions	effitributing to death but not re	sulting in the und	erlying cause given in I	Part I. 24s. WAS AN PERFORE	AUTOPSY 346	MAILABLE PRIOR TO
ă	AHAM	THE STATE	with mi	1 6000	Levis F.	Ame	ON PLETION OF CAUSE ON DEATH?
ž	DID TOBACCO USE CO	NEDIBLITE TO CALIS	OF DEATH	YES TO NO		7	1 VES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRID TO MEDICAL	TAIKIBOTE TO CAUSE	OF DEATE	M. PLACE OF BEATH /C/N		y	colle
Sic		OSPITAL:	DOA SON	ng Home 5 Residence	1/		
Ť	27. MANNES OF DEATH	28s. DATE OF INJURY	286. TIME OF 2	Sc. BIJURY AT	26d. DESCRIBE HOW IN	JURY OCCURED	
ВУР	1 Natural S Pending 2 Accident Investigation	(Month, Day, Near)	INJURY M	WORK? 1 ☐ YES 2 ☐ NO			
	3 Suicide 6 Could regide	28s. PLACE OF INJURY — At hors suilding, etc. (Specify)	e, farm, atreet, factor	y, office	28f. LOCATION (Street a City or Savo, State)	nd Number or Rurel	Noute Mumber;
E	4 Homicide determined	8 6 88					
APL.		It the best of my knowledge, dear					
COMPLETED	2 MEDICAL EXAMINER: C	On the beats of examination special in	vestigation, in an opi	nigs, death opcored at the	time, data and place, and	f due to the cause)	i) aget manner as stated.
BR	290. SIGNATURE AND TITLE OF CERTIFIER	11/1/11	11.1119	29c. LICENSCHIEM	129	29d. DATE SIGNAL	(Monter Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CARSE OF DEATH ATTEND	27) (Time Drive)	00011	10	11/9	70
	David M. Federle	MD 600 Moakley	St. #20	6 Leonardto	wn, MD 206	50/	
	31. DATE FILED (Month, Day, Year) 1995	32. REDISTRAR'S SIGNATURE					
	NUV () 6 1995	Julia Studen Re	rdall				



ie death certificate be executed with burns after death. Page 6 may be retained by the hospital or attending physician.	the attending physician and complete, and in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should	Mental Hygiene prior to burial, cremation, or removal.	jury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	ERAL DIRECTOR: After this certificate has been signed by the attending physician and complete,	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation,	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the
TO THE HOS	TO THE FUNERA	be filed with	IMPORTAN

BE

2

29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8 1995

WILLIAM F. HARPER, M.D. 100 S. CENTER ST., THURMONT, MD 21788

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY VEAR 1995 рм CHARLES NOV. 9:45 LAMAR RICE 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs. lest birthdev) IF UNDER 1 YEAR IF UNGER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MONTHS DAYE HOURS MIN. 1 🕅 M 2 🗆 F YRS. DEC. 26, 94 1900 214-10-1722 MARYLAND 9e. FACILITY NAME (If not institution, give atreet end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 13730 CATOCTIN FURNACE RD. THURMONT FREDERICK RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 10e. STATE MARYLAND FREDERICK FREDERICK 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10331 PUTMAN RD. 21702 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO If yes, epecify Cuben, Mexicen, Puerto Rican, stc.)

1 ☐ YES 2 X NO Specify: 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5+) 8 BRUSH MAKER OX FIBER BRUSH COMPANY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **GEORGE** RICE ANNICE BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 EDWARD E. RICE (SON) 2469 FIVE SHILLINGS RD., FREDERICK, MD 21701 20e. METHOD OF DISPOSITION
1 № Buriel 2 □ Crametion 3 □ Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — Cify or Town, State LEWISTOWN CEMETERY 11/6 LEWISTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN ST., THURMONT, MD 21788 Enter the diaeases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat, shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Finsi disease or condition mo avereal resulting in death) Ca DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significent conditions contributing to death but not reauting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a, WAS AN AUTOPSY MEDICAL 1 - YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 YES ZXXNO 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 ☐ Nursing Home 5 🖾 Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1X Natural М 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be COMPLETED 4 Homicide 29e, CERTIFIER 1 To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or impetitation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated.

29d. DATE SIGNED (Month, Day, Year)

1995

NOV. 3,

29c. LICENSE NUMBER

recording your

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitled at once.
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	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPART	CATI	T OF H	DEAT	AND !	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)	7							2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
			addus F 8. AGE (In yrs. les	t birthday)	IF UNDER		JF UNDER 2		Oct.25		8. BIRTHP	02:35 A M
	0,7 21 0007	□ M 2 💢 F	70	YRS.	MONTHS	DAYS	HOURS	MIN.	June 30	,192		ash.D.C.
OR	90. FACILITY NAME (If not institution, give street Anne Arundel Me		Center	r			a poli		ATH		ine A	rundel
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY					OR LOCAT			<u> </u>			18d. INSIDE CITY
		Anne's	3		Ste	ven:	svil	le				1 PES 2 THO
FUNERAL	100. STREET AND NUMBER 307 Queens Court 101. ZIP CODE 21666 U.S.A											
BY	11. MARITAL STATUS 1 Never Merried 2 Noverried 3 Widowed 4 Divorced	P. WAS DECEDENT FORCES? 1 [IF YES, GIVE WI	YES 2 TH	MED Y		If yes, sp	ecify Cuben,	HISPAN Mexices Specify	IC ORIGIN? (Specify n, Puerto Rican, etc.)	res or No-	14. RACE Black, Specify	- American Indian, White, etc. White
LETED		npleted) College (1-4 or 5+)	(G life.		ork done retired.)	during mo	ON st of working		16b. KtND OF E	BUSINESS/IN	DUSTRY	
BE COMPLET	1. FATHER'S NAME (First, Middle, Last)	2	H	omem	ake	r	18 MOTHE	O'C MAI	ME (First, Middle, Maid	- Comment		
E C	Lawrence Eugene	Broad	dus				Му	rtl	e White	en Sumeme)		
10 B	190. INFORMANT'S NAME (Type/Print) William O. Ritte	ar							Poute Number, City or 1			
9	20e. METHOD OF DISPOSITION		20b. PLACE	AND DATE O	FDISPOS	SITION (Na	me of		Rd., Lot	OCATION -	City or Tow	on State
	1 Donation 5 Other (Specify)	1rom State	cemetery, cre Met	matory or oth	ner place)	ato	rv O	ct.	25, 19	95 Ba	altin	nore, Md.
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Velle	1	_	_ ^{22.} T	OM .	Helfe	enb	ein Fun	eral	HOme	es, P.A. Md. 21619
	23. PART I. Enter the diseases, Dr com ahock, or heart failure. Lie	plications that	caused tha de	ath. Do no	ot anter	the mo	da of dyin	g, auch	na cardiac or rea	piratory ar	rest,	Approximata
	IMMEDIATE CAUSE (Final disease or condition	, -	_									Interval Between Onset and Death
	resulting in death) a	DUE TO (OR AS A CONSEC	DUENCE OF	<u>/</u>):							
N	Sequentially list conditions, b	Ein.		1								
ATIC	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A CONSEC	QUENCE OF):							
ERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A CONSEC	DUENCE OF):							
Ö	PART ii. Other aignificant conditions of	ontribution to	feeth but not n	esultina ir	the un	ad a dada a		unn In I	2-41 2 2 2			
PHYSICIAN: MEDICAL	In concerated Umh	real A	unia	wit	4	2	My	las		ORMED?		WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
ž	DID TOBACCO USE CONTRIB	UTE TO CAL	JSE OF DEA	TH YES	S 🗆 I	NO 🗵	UNCE	RTAIN	10	,		1 TES 2 NO
ICIA		OSPITAL:		E OF DEATI	OTHER							
HYS	1 TYES 2 NO 97	28e. DATE OF I	NJURY	28b. TIME	OF	28c. INJ	URY AT	dence i	8 Other (Specify) 28d. DESCRIBE HOY	/ INJURY OC	CURED	
ВУ Р	Natural 5 Pending Investigation	(Month, Day	y, Year)	INJU	M M		PK7	но				
	3 Suicide 8 Could not be determined	28e. PLACE OF building, s	INJURY — At horte. (Specify)	me, farm, at	reet, fect	tory, office			28t. LOCATION (Stree City or Town, Ste	t and Numbe	r or Rural Ro	ute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: C											and manner as stated
ш	29b. SIGNATURE AND TITLE OF CERTIFIER			- CERTIFIC			29c. LICEN					Month, Day, Year)
TO B	30 NAME AND ADDRESS OF PERSON WHO C	OMPLETED OUT					D 2	51	78	•	10/	125/95

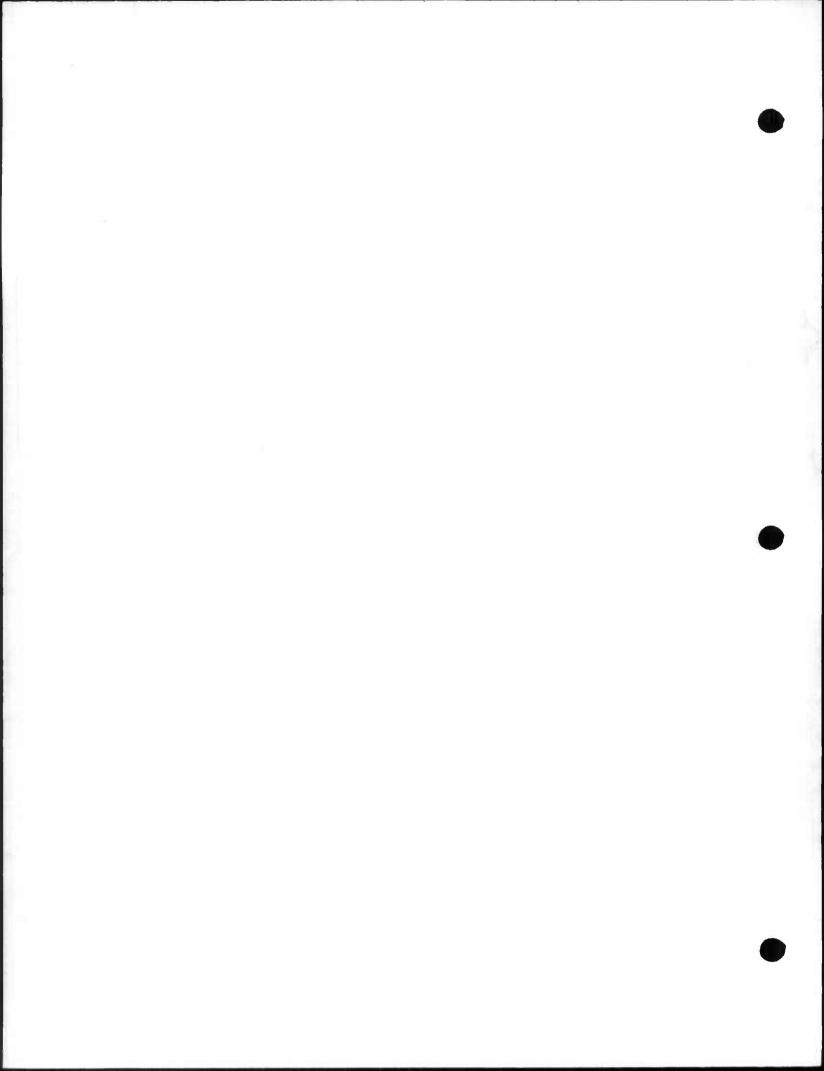
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MORRE

Anne Arende M. REGISTRAR'S SIGNATURE Juli Banders Paris

ROBERT

31. DATE FILED (Month, Day, Year)
OCT 25 1995



S(n) DIVISION OF VITAL REC	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires	TO THE FUNERAL DIRECTOR: After this certificate has been sign be filed within 72 hours after death with the State Dept. of Heal	IMPORTANT: If Item 28 is marked, or Item 23 shows
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	VSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, p. th the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
BALTIMORE, MARYLAND 21215-0020	be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	be notified at once.

1. DECEDENT'S NAME (First FRED JAMES		BAUM					oct	27, T	995		3. TIME OF DEATH 1:28PM
4. SOCIAL SECURITY NUM 214-05-805		5. SEX 1 M 2 F	6. AGE (In yrs. lest	44	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	ARCH 1	1, 19	-Control	LACE (State or Foreign
90. FACILITY NAME (If not SACRED HEA	Institution, give s		, , ,	9		OR LOCATION OF DI	EATH			ALLEG	ATH
RESIDENCE OF DE 100. STATE MARYLAND	10b. COUNT	RETT		10c. CITY,	TOWN OR LOCA STBURG	TION					10d. INSIDE CITY LIMITS? 1 YES 2 X NO
100. STREET AND NUMBER 2245 PC		AS ROAD			10	1. ZIP CODE 21532				USA	HAT COUNTRY?
					If yes, sp	CENDENT OF HISPAL secify Cuben, Mexics XXX NO Specif	in, Puerto I		or No—	14. RACE Black, Specify	American Indian, White, etc.
	CEDENT'S EDU		(GI		SUAL OCCUPATION And Advised In the Country of the C		16b	. KIND OF BUS	SINESS/IND	USTRY	1915
12		2+		VAGER				SURVE			
17. FATHER'S NAME (First, FREDERIC	Middle, Last) CK ROSE	ENBAUM				16. MOTHER'S NA MARIA	KANE	Widdle, Malden	Sumame)		
20e. METHOD OF DISPOSI KXBurlel 2 [] Cremate Donation 5 [] Other 21. SIGNATURE OF FUNES	ion 3 🗌 Ren er (Specify)		20b. PLACE A cemelery, cre SACRED	AND DATE OF other HEAR	22. NAME A	PRAL 1000 P	DAT 0/30/	95 JOH	ANSTO	WN, I	rn, State PA
X Burlal 2 Cremat Donation 5 Oth Signature of Funes 23. PART I. Enter the	disease, or heart feliure.	complications the Liet only one cells. ARTERIOS DUE TO DUE TO C.	20b. PLACE A cemelery, cre SACRED	eeth. Do no C CARD OUENCE OF):	PIROPOSITION (NOTE PARTIES AND ASSETS ASSETTS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETTS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETTS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETTS ASSET	PROST AVE	DAT 0/30/ MCILITY MANSI ., FR	20c. LO 95 JOH ON FUN ROSTBUH disc or respi	HNSTO VERAL RG, MI	WN, I HOMI D 2	PA E 1532 Approximate interval Between
23. PART I. Enter the shock, or iMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to immesuse. Enter UNDERL CAUSE (Disease or Intel Initiated events	diseases, or heart feilure.	CENSEE Complications the Liet only one complication on the Liet only one complete the Lieu one c	20b. PLACE A COMBECT OF DEAL COMBET	eeth. Do no e. C CARD OUENCE OF: OUENCE OF:	DIOVASCI	PROST ICAN PROST IN ADDRESS OF FIRE PROST AVE DODG OF DIE PROST AVE DOG OF DIE PROST AVE DIE	DATE DATE DATE DATE DATE DATE DATE DATE	20c. LO 95 JOH ON FUN ROSTBUH disc or respi	CATION — CANADA	HOMID 2.1	PA E 1532 Approximate interval Between Onset and De UK YRS WERE AUTOPSY FINDIN AMILABLE PRIOR TO
23. PART I. Enter the shock, or iMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in thet initiated events resulting in death) LA	diseases, or heart feliure.	CENSEE Complications the Liet only one complication on the Liet only one complete the Lieu one c	20b. PLACE A COMBECT COMMENTS OF DEA	eeth, Do no C CARD OUENCE OF): OUENCE OF): Teauiting in	PISPOSITION (Ner place) The HOSP 22. NAME A HAFE! 58 F) St enter the me DIOVASCI The underlying the under	PROST IN ROST AVE DODGE OF GLOVE OF GLO	DATE DATE OF THE PART I.	E 20c. LO 795 JOH CON FUN ROSTBUI disc or respi SEASE 24a. WAS AN PERFOI 1 VES 2	CATION — CHINSTO	HOMID 2.1	Approximate interval Betwee Onset and De UK YRS WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?
23. PART I. Enter the shock, or immediate Cause (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in thet initiated events resulting in death) PART II. Other algnification of the condition of the condit of the condition of the condition of the condition of the condi	diseases, or heart fellure. distance Lister	CENSEE Complications the Liet only one complications the Liet only one complete the Liet only one contributing the Lieu one contribution the Lie	20b. PLACE A COMBECT COMPANY COMBINE C	eeth, Do no C CARD OUENCE OF): OUENCE OF): Teauiting in	PISPOSITION (Ner place) THE HOSP 22. NAME A HAFE! 58 F! ot enter the me DIOVASCI The underlying the under	PROST IVERTAL TYPE REST AVE DODE OF DIVINITY DILAR HEAD DILAR	DATE DATE OF THE PART OF THE P	E 20c. LO 795 JOH CON FUN ROSTBUI disc or respi SEASE 24a. WAS AN PERFOI 1 VES 2	HNSTO	HOMID 21	Approximate interval Betwee Onset and De UK YRS WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?
23. PART I. Enter the shock, or immediate Cause (f disease or condition resulting in death) Sequentially list cond if any, leading to immediate. Enter UNDERL CAUSE (Disease or in the initieted events resulting in death) PART II. Other algnification of the condition of the con	diseases, or heart feliure. distance Lister	CENSEE Complications the Liet only one centre of the Liet	20b. PLACE Comeley, cre. SACRED Let couled the depuse on each line SCLEROTIC O (OR AS A CONSECT O (OR	DOUENCE OF: OUENCE OF:	DIOVASCI The underlyin The underly	TRAL 10 ITAL 10 ROST AVE DILAR HEAD OF THE PROST IN T	DAT DATE OF THE PART OF THE PA	E 20c. LO 95 JOH ON FUN OSTBUI disc or respi SEASE 24a. WAS AN PERFOI 1 VES 2	HNSTO	HOMID 21	WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?
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23. PART I. Enter the shock, or immediate Cause (F disease or condition resulting in death) Sequentially list cond if any, leading to immediate. Enter UNDERL CAUSE (Disease or in thet initiated events resulting in death) LA PART II. Other algnification of the condition of the	diseases, or heart feilure. Ittions, ediete ying jury ST TO MEDICAL Pending investigation Could not be determined RTIFYING PHYST REAL EXAMPLES	CENSEE Complications the Liet only one central only only one central only only one central only only only one central only only only only only only only onl	20b. PLACE A COMBETCH COMBINETY COMBINING THE COMBINING COMBINING COMBETCH COMBINING C	DOUENCE OF: OUENCE OF: OUENC	PISPOSITION (Ner place) 22. NAME A HAFE! 58 F] St enter the me DIOVASCI The interplace of the underlying of the und	PROST IN ROST AVE. COMMON TO STATE THE PROST AVE. COMMON TO	DATE DATE DATE DATE DATE DATE DATE DATE	24e. WAS AN PERFOI YES 2	AUTOPSY RMED? and Number and Number and due to the	HOMID 21 eat, 24b.	WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

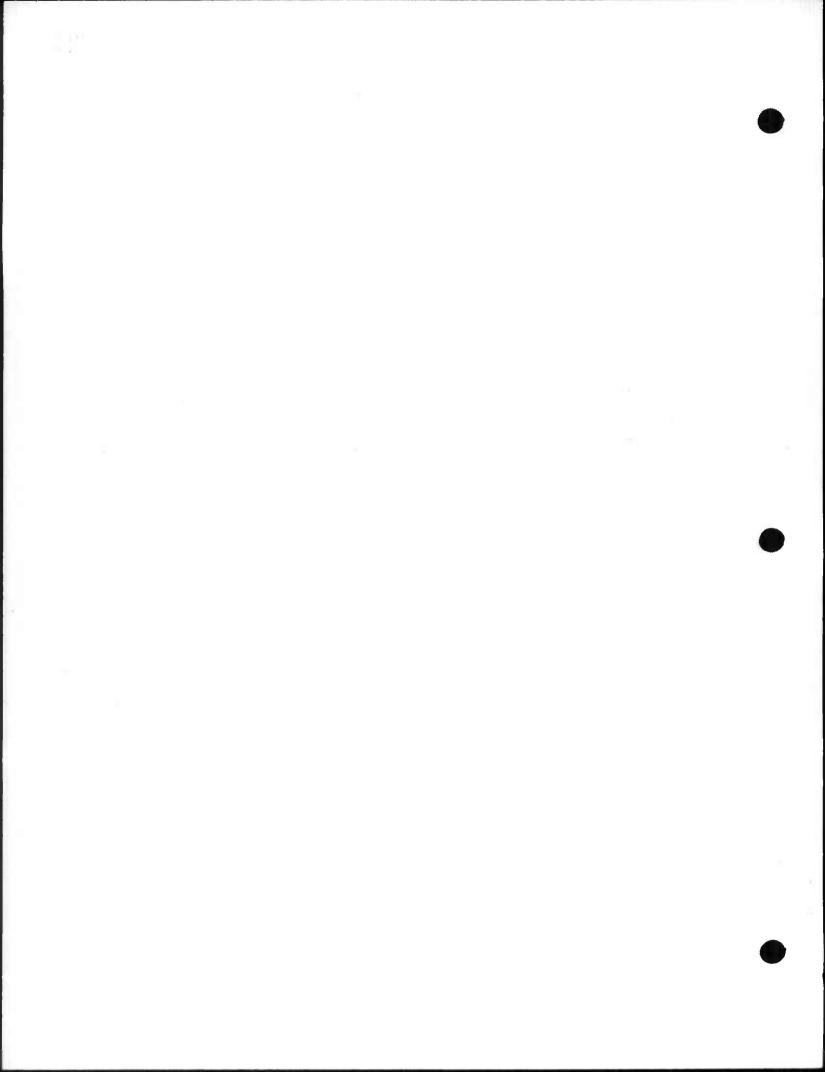
IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR REGIS	E STRAR		STATE OF I	MARYLAND	/ DEPART	MENT 0	F HEALTH AND	MENTAL HYGIEN		
1. DECEDE	A DESCRIPTION AND SELECTION OF THE SELEC					2. DATE OF DEATH	3. TIME OF DEATH			
	MILI		C. E.	REE	SE			OCTOBER 2	7 1995	20:11 M
	SECURITY NUME		5. SEX	6. AGE (In yrs.		IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year)	8. Bif	ITHPLACE (State or Foreign intry)
	10-1675		1 - M 2 - F	80	YRS.			OCT 15, 1	915 PE	NŃSYLVANIA
MEMOR		SPITAL	treet and number)	L CENT			WN OR LOCATION OF DE ERLAND	EATH	9c. COUNTY OF	
10a. STATE		10b. COUNT	Y		10c. CITY,	TOWN OR L	OCATION			10d. INSIDE CITY
PA 10e, STREE	T AND NUMBER	BED	FORD		H	YNDMA	N 10f. ZIP CODE		La artimoria	LIMITS?
Р.	O. BOX	195,	APT 209,	MELAWA	RE API	S	15545		USA	F WHAT COUNTRY?
	L STATUS Married 2 wed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2X	ARMED NO	If yes	DECENDENT OF HISPA I, specify Cuben, Mexico YES 2 NO Speci		Bi	NCE — American Indian, ack, White, etc. ecity: WHITE
Element	(Specify onlinery/Secondary (C	EDENT'S EDU y highest grade	CATION completed) College (1-4 or 5		lle. Do NOT use	rk done durin retired.)	ATION g most of working		SINESS/INDUSTRY	
	8					ERK			L GROCE	RY
НС	S NAME (First, M)WARD	BOHN					LAURA)	
	USAN L.						eet and Number or Rural 122, HYNDM	AN, PA 1	vn, State, Zlp Code) .5545	
1 (Z) Burlel	DD OF DISPOSIT 2 Crematic ion 5 Other	n 3 🗆 Rem	oval from State		remetory or oth RGER C			1	BUFFAL	Town, State
21. SIGNATU	FUNERA	L SERVICE LIC	ENSEE			HAR	E AND ADDRESS OF FA	GLER FUNER	AL HOME	o including in
23 DADT	L Enter the d	111	omelidadises the		to the Donate	HYN	DMAN, PA	15545-063 th as cardiac or reap	36	
IMMEDIAT	shock, or here CAUSE (Fire condition in death)	eart tellure.	a. Acute 1	se on each ili	ial In	farct		en as cardiac or reap	iratory arrest,	Approximeta Intervel Between Onset and Death 8 Days
if any, lea cause. En CAUSE (D that initial	ally list condition to immediate the condition of the con	diete NG Iry	с	(OR AS A CONS						
PART II. C	other signification in the signification is significant. The significant is significant in the significant in the significant is significant. The significant is significant in the significant in the significant is significant. The significant is significant in the significant is significant. The significant is significant in the significant is significant in the significant is significant. The significant is significant in the significant is significant in the significant is significant. The significant is significant in the significant is significant in the significant is significant. The significant is significant in the significant is significant in the significant is significant. The significant is significant in the significant is significant in the significant is significant. The significant is significant in the significant is significant in the significant is significant. The significant is significant in significant is significant in the significant is significant in s	nt <u>condition</u> Mellit	s contributing to	death but not	resulting in	the under	ying cause given in	Part I. 24a. WAS AN PERFOI	RMED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
DID TO	OBACCO U	SE CONTI	RIBUTE TO CA	USE OF DF	ATH YES	Пио	UNCERTAI	N []		1 YES 2 NO
11	SE REFERRED TO				CE OF DEATH					
	S 2 X NO		HOSPITAL:	ER/Outpatient		OTHER:	Home 5 - Reeldence	8 Other (Specify)		
27. MANNER OF DEATH 1 Netural 5 Pending 28e. DATE OF INJURY (Month, Dey, Year) 29b. Time OF INJURY WORK? 1 Netural 5 Pending 28c. INJURY AT WORK? M 1 VES 2 NO										
2 Accklent Investigation 3 Suicide 6 Could not be determined							I Route Number,			
29e. CERTIF (Check one)	only KI CERT							to the cause(e) end me		e(e) end manner ee stated.
29b. SIGNAT	UNE AND TITLE						29c. LICENSE NUI			ED (Month, Day, Year)
Re	bustic	m 0).	. Hen	aple.			D 2891		OCTOR	
II .			MEMORIA					, CUMBERLA		21502
31. DATE FIL	ED (Month, Day,	Ybar)		R'S SIGNATURE				,		
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF HEALT		TAL HYGIENE REG. NO.				
1	1. DECEDENT'S NAME (First, Middle, Lest)					TE OF DEATH	- -	3. TIME OF DEATH		
	CAROL Tre	ere RAINEY	7			OBER 24	1995	15:30	м	
	4. SOCIAL SECURITY NUMBER		yrs. last birthday)		DER 24 HRS. 7. DA	TE OF BIRTH	8. BIRT	HPLACE (State or Foreig	gn	
1	302-34-1422	1 - M 2 X F 5	5 YRS. MO	NTHE DAYS HOURS		onth, Day, Year) 7 y 14, 19	40 Pol	unsylvani	10	
	9a. FACILITY NAME (If not institution, give s	treet and number)	91	CITY, TOWN OR LOCA			e. COUNTY OF		14	
DIRECTOR	MEMORIAL HOSPITAL	& MEDICAL CF	ENTER	CUMBERLAND			ALLEGA	AA.		
ECT	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	v		DWN OR LOCATION			TIBBECT			
E I	1000000	egany		uberlo	and			10d. INSIDE CITY LIMITS?		
	10a. STREET AND NUMBER	7-17		101, ZIP CO			IO- CITIZEN OF	1 X YES 2 NO		
FUNERAL	235 Paca 57	: Aut. #60	/	67, 7,	1502					
Ž	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DECENDENT		GIN? (Specify Yea or	U 5		-	
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	II yes, specify Cu	ban, Maxican, Puer	to Rican, etc.)	Ble	CE — American Indian, ck, White, atc.		
ВУ	3 Widowed 4 Divorced				о преспу.		Spe	white		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18e. DECEDENT'S USI	JAL OCCUPATION done during most of wor	deina	16b. KIND OF BUSIN	ESS/INDUSTRY		\neg	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)	All Ag					
MP	12.		Hous	ewife		HOL	Me			
8	17. FATHER'S NAME (First, Middle, Lest)			16. MC		t, Middle, Meiden Su	,			
BE	Harold Po	Quette			Helen					
9	19a. INFORMANT'S NAME (Type/Print) Debora Sta	11:400		DRESS (Street and Numl	ber or Rural Route No	umber, City or Town, S	State, Zip Code)	21502		
			12706		VIEW F	xve, CI	esapt	own, mo	1,	
	20a. METNOD OF DISPOSITION 1	oval from Stata 20b. I	PLACE AND DATE OF Ditery, crematory or other	ISPOSITION (Name of place)	10-0	ATE 20c. LOCAT	FION — City or 1	Town, State Moryloa		
	21. SIGNATURE OF FUNERAL SERVICE LIC		SThaven	Cremate 22. NAME AND ADD	ory	Ps Fred	evicti	Morylow	d	
	· Ernest a.					c 230 B	altimor	e Avenue		
				Cumberla	nd.Md.	21502		c Avenue	_ [
	23. PART I. Enter the diseases, or o	complications that caused List only one cause on each	the deeth. Do not	enter the mode of o	lying, such as c	ardiec or respirat	ory arrest,	Approximate		
	IMMEDIATE CAUSE (Fine)	List only one cause on ear	CIT IIIIE.					Interval Betw Onset end De		
	disease or condition									
		DUE TO (OR AS A	CONSEQUENCE OF):						\neg	
Z	Sequentielly list conditions,	Hypercarbia						l Week		
Ĕ	if any, leeding to immediate	Hypoxia	CONSEQUENCE OF):					D. LTo olars		
5	CAUSE (Disease or injury	C	AND COLUMN OF					2 Weeks		
Ē	that initiated events resulting in death) LAST	DUE TO (OH AS A (CONSEQUENCE OF):						- 1	
CERTIFICATION		1								
AL	PART II. Other significant condition	s contributing to deeth bu	t not resulting in t	ne underlying ceuse	given in Part I.	24a. WAS AN AU		b. WERE AUTOPSY FINDI	NGS	
2						PERFORME 1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUS	SE	
MEDIC								OF DEATH? t □ YE\$ 2 □ NO		
ä	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH YES	NO UN	CERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEATH (
Š	1 TYES 2 NO	HOSPITAL:		HER: Nursing Nome 5	Residence 8 - Ot	her (Specify)				
E	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. D	EŞCRIBE NOW INJU	JRY OCCURED			
B⊀	1 Natural 5 Pending 2 Accident Investigation			M 1 TES 2	□ NO					
ED	3 Suicide 6 Could not be	28e. PLACE OF INJURY - building, etc. (Specifi	At home, Jarm, stree	t, factory, office	28f. Lf	OCATION (Street end ity or Town, State)	Number or Rural	Route Number,		
	4 Nomicide detarmined	/				,				
2	29a. CERTIFIER t CERTIFYING PNYSI	CIAN: To the best of my knowle	dge, death occurred at	the time, date end place	ce, and due to the	cause(a) and manner	as stated.			
COMPLET	one) 2 MEDICAL EXAMINE	P. On the basis of examination	and/or investigation, in	my opinion, death occ	ured at the time, de	nta and place, and d	ue to lhe cause(a) and menner as state	d.	
	29b. SIGNATURE AND TITLE OF CERTIFIER				CENSE NUMBER			D (Month, Day, Year)	-	
) BE	1//1	140/2	and the same of th		36766		ОСТОВ			
2	30. NAME AND AGORESS OF PERSON WIN	COMPLETED CAUSE OF DEAT	TN (ITEM 27) (Type, Prin	0	0700		OCTOR	EK "		
	DR. VIK POONAI, 45	5 FREDERICK	ST., CUMBI	ERLAND. MT	21502)				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TURE	111	21002					
- 1	DOTO 0 400E	11: Be 's	E							



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the viring after death. Page 6 may be retained by the hospital or attending physician	• TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tra	be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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S'ATURNINA T. CHANG

OCT 26 1995

31. DATE FILED (Month, Day, Year)

Amended # 196, 10/26/95, N&S, allegary Co. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OCTOBER 23 ROBERTSON 01:30 WILBUR **EDWARD** 1995 8. AGE (in yrs, last birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. Aug. 30, 1914 Maryland 214-07-2634 1X M 2 - F 81 Sacred Heart Hospital 96. CITY, TOWN OR LOCATION OF DEATH Cumberland Allegany DIRECTOR RESIDENCE OF DECEDENT Allegany 10c, CITY, TOWN OR LOCATION LONG 10s. STATE 10d. INSIDE CITY LIMITS? Maryland 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA FUNERAL 10m. STREET AND NUMBER 21539 8 West Florida Way, Lonaconing, Md. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. MARITAL STATUS RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR OATES 1 YES 2 XNO Specify sowhite BY 3 Widowed 4 Divorced WII COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY mtary/Secondary (0-12) College (1-4 or 5 +) Textile Labor 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Staup Edward Robertson Molly. 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 West Florida Way, Lonaconing, Md. 21539 Linda Inskeep 20b. PLACE AND DATE OF TOWN, Stete Prostburg Ment. Park Oct. 26, 1995 Frostburg, Md. 20a. METHOD OF DISPOSITION

1 N Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21 SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539 23. FARY. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, ahock, or haart failure. List only one cause on each line. Interval Batween Onset and Dawth IMMEDIATE CAUSE (Final disease or condition RESPIRATORY Failure 14 hrs reaulting in death) DUE TO OR AS A CONSEQUENCE OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter tJNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evanta resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS CARDIOMYSPATHY, CARDIAC DYSRHYThrain AWAR ARLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 AO CONSTITUTE HEART FAILURE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Topatiant 2 - ER/Outpatiant 3 - DOA 4 🗌 Nursing Home 5 🗆 Rasidenca 8 🗆 Other (Specify) 27. MANNER OF GEATH 28s. DATE OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide a Could not be COMPLETED 4 Homicida 29a. CERTIFIER

(CARTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as attend. 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

hangers. D OCTOBER 24, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FROSTBURG FROSTBURG MARYLAND 30. REGISTRAR'S SIGNATURE
Julia d'Aurelion Rochall

29d. OATE SIGNEO (Month, Day, Year)

S. A. H. J.

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e 6 may be retained by the hospital or attending physician. rector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

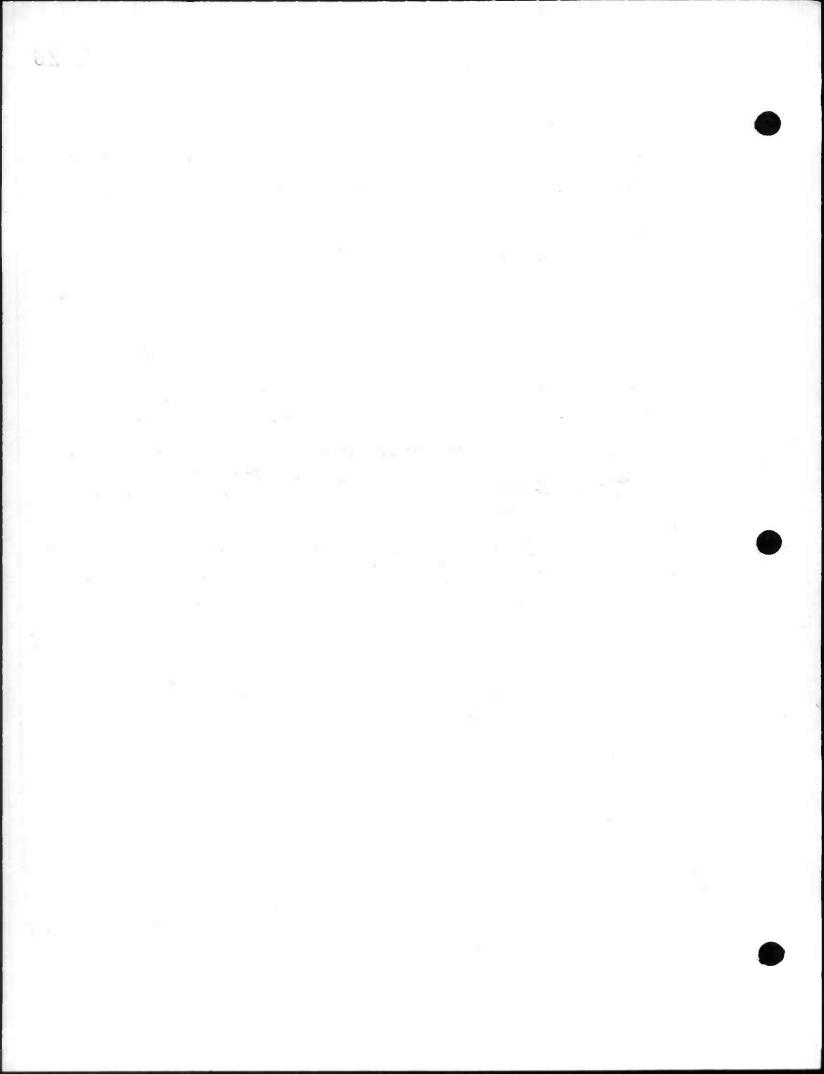
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•	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	INERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dis-

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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF H	DEATH AND	MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)			-		2. DATE OF DEATH	NY YEA	3. TIME OF DEATH		
	RICHARD LEE					0-1-1	20 199			
	V CONTRACTOR OF THE CONTRACTOR	The second secon	yrs. last birthday)	# UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH APRIL 24, 1	8. Bi	RTHPLACE (State or Foreign		
	217-78-8104 9e. FACILITY NAME (If not institution, give etree	1X(XM 2 □ F 3	4 YRS.					MARYLAND		
œ	WASHINGTON COUN			7.	RSTOWN	EATH	9c. COUNTY O	F DEATH		
6	RESIDENCE OF DECEDENT	TT HOST ITA		IIAGLI	HOTOWN		WASH	INGION		
DIRECTOR	10a. STATE 10b. COUNTY	THOTON	1	Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?		
	MARYLAND WASH	INGTON	Н	AGERST				N☐ YES 2 ☐ NO		
FUNERAL	234 NORTH POTOM	AC STREET		101	21740		U.S	. A .		
	1X Never Married 2 Merried	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	X X NO	If yes, sp	CENDENT OF HISPAN ecity Cuban, Mexica 2 NO Specific	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	В	ACE — American Indian, lack, White, atc.		
ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUCAT	TION 1	Be. DECEDENT'S	USUAL OCCUPATION	DN	16b. KIND OF BUS		P ^{oc/fy} WHITE		
COMPLETED	(Specify only highest grade co	college (1-4 or 5+)	(Give kind of life. Do NOT us	work done during mo	st of working	Note Killo of Boo	INC33/IND03TH	,		
MP.	11		BODY	MECHANI	IC	TRUCK	PAINT:	ING COMPAN		
00	17. FATHER'S NAME (First, Middle, Last)	2.705			A Maria Company of the Company of th	ME (First, Middle, Meiden				
BE	ROBERT LEE	RICE			MARYE			THERFORD		
2	190. INFORMANT'S NAME (Type/Print) GARY LEE RICE					Acute Number, City or Town				
20e, METHOD OF DISPOSITION ACC Burlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of ACC Burlet 2 Cremetton 3 Removal from State Remo										
	X X Buriel 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State BAK		E PICEMETE				LE, MARYLAND		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	0		32NAMEAN	NO ADDRESS OF FA	FMAN FUNERA	I HOME	TNC		
	· R. hall to			40 E.	ANTIETAN	M ST., HAGEF	RSTOWN,	MD. 21740		
	23. PART I. Enter tha diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory strest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final Approximate interval Between Onest and Death									
	disease or condition resulting in death) Lordin - Legginatory Tailine Munita									
	(DUE TO OR AS A O	ONSERBENCE OF	7-1	1/00			7		
ON	Sequantially liet conditions,	DUE TO JOB AS A CO	CHALLA OF	we A	C/ 483)	02	·	1) ay 3		
ERTIFICATION	If sny, laading to immedieta cause. Entar UNDERLYING	laute	Her	in Le	e Fac	lune		Dues		
Ē	CAUSE (Disease or Injury that Initiated events resulting in death) LAST									
CER	prompte fire Visiail grand									
EDICAL	PART II. Other significent conditions	contributing to death but	not resulting	in the underlying	g cause given in	Part I. 24a. WAS AN PERFOR		246. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
EDI						1 YES 2	NO	OF DEATH?		
Σ	1 TES 2 NO									
AN	25. WAS CASE REFERBED TO MEDICAL			TH (Check only one)	UNCERTAIN	101				
PHYSICIAN		HOSPITAL: ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 🗆 DOA	OTHER:	e 5 🗆 Residence	8 Other (Specify)				
Ĭ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Yeer)	28b. TIM	E OF 28c. INJ		28d. DESCRIBE HOW IN	JURY OCCURED			
BY	2 Accident 5 Pending Investigation			M 1 🗆 Y	rES 2 NO					
9	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, i	street, fectory, office	•	281. LOCATION (Street e. City or Town, State)	nd Number or Rur	al Route Number,		
	29e. CERTIFIER 1 CERTIFYING PHYSICIA	IN: To the heat of my innufed	no double consum	4 4 4 4 4 4 4 4			est Johnson			
OMPL		N: To the best of my knowled On the basis of examination						e(s) end menner se stated.		
ECC	394. WHYTURE AND TITLE OF CENTIFIER	1/11/20	17	N 1	29c. LICENSE NUN			ED (Month, Day, rear)		
3	Marken IN	Fellet N	VIA		D7	1880	10	122/95		

TRMP



VEAD

9c COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

USA

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country) Rainell W. Virginia

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

SpecifyWHITE

1 YES 2 NO

3:25 PM w

REG. NO.

2. DATE OF DEATH

979/1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

this ce marked,

BY

COMPLETED

BE

9

DIRECTOR: After the hours after death

FUNERAL C HOSPITAL

표

2 23

hours a

28 Is 1

IMPORTANT: If Item

1. Natural

2 Accident

3 Sulcide

29e, CERTIFIER

4 Homicide

(Check only one)

30. NAME AND ADDRESS OF

31. DATE FILED (Month, Day, Year)

29b. SIGNATURE AND TITLE OF CERTIFIES

5 Pending

6 Could not be

Investigation

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

Manuel

E.

RAMSEY

4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 2/3/1910 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 232-18-3996 HOURS 1 M 2 | F 85 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH Colton CVillia Nursing Home DIRECTOR Hagerston RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Hagerston permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 703 E. Washington St. burial-transit #705 21740 ours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Married IF YES. GIVE WAR OR DATES BY 3 Wildowed 4 ☐ Olvorced use as the COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KING OF BUSINESS/INDUSTRY detached for Elementary/Secondary (0-12) College (1-4 or 5+) in in orace PAINTER 17. FATHER'S NAME (First Middle, Last) George M. Ramsey e notified at BE page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Godby Box 9 20e. METHOD OF DISPOSITION
1 Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Georgetown Med. Sch. funeral director, 4 N Donation 5 Other (Specify) 9/9 the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY npletely filled in by the cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) ATHERO SCLEROTIE and completely event, DUE TO (OR AS A CONSEQUENCE OF): that the death certificate be executed wil PRO FILERATIVE prior to burial, OUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate the attending physician CHRONIC OBS TRUCTIVE AIRWAY DISEASE DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury Injury, or other that initiated events resulting in death) LAST DEMEN TIA Mental PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL signed by the Health and shows any Health a DR ATTENDING PHYSICIAN: The law requires peen ō has be PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate t **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 the 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF

Day, Year)

C. (SI

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

3. REGISTRAR'S SIGNATURE

28e. PLACE OF INJURY — At home, ferm, street, factory, office

1 YES

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Self Employed 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rachel Ann Blake 75, Hadgesville, W. Virginia 25427 20c. LOCATION — City or Town, State \$5 Washington, D.C Austin Royster Funeral Home 3605 14th St. N.W. Wash, DC 20010 Approximate Interval Batween Onset and Death 3 YFAPS CARDIO YASULAR 14BAR 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 1 TYES 2 NO 28c. INJURY AT 28d. OEŞCRIBE HOW INJURY OCCURED ATN/A 26f. LOCATION Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 8 3 6 DHMH-16 Rev 1/89 DIVISION OF VITAL RECORDS, P.O. BOX 68760 And BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Degr. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOK 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF OEATH	AY - 16	VEAR 3	TIME OF DEATN
			ward				907	ober1.	5 19	95	1800 M
	4. SOCIAL SECURITY NUMBER		E (In yrs. last bin	MONTHE	1 YEAR DAYS	HOURS MIN.	(Month	DE BIRTN Day, Year)		Country)	ACE (State or Foreign
	191-24-9737	1 X M 2 F	90	YRS.				11,			sylvania
OR	98. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County Be. COUNTY OF D Elkton Gecil									TN	
ECT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	1	10	Oc. CITY, TOWN O	R LOCA	TION				10	Dd. INSIDE CITY
DIRECTOR	Pennsylvania Ches	ster		Lewisv	i11	e				1	LIMITS?
	10e. STREET AND NUMBER				10	f. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
ER/	104 Brick Meetin	ng House Roa	ıd			19351			U.	S.A.	
FUNERAL	11, MARITAL STATUS 1 X Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE				ENDENT OF NISPAI			a or No-		- American Indian, White, atc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR		1	YES	2 X NO Specif	fy:	V.		Specify:	White
TEL	15. DECEDENT'S EDU (Specify only highest grade		(Give in	DENT'S USUAL Of	CUPATE during me	ON ost of working	16b.	KIND OF BU	ISINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)		nter			_ p	ainti	no s	e1f-e	employed
OMI	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA				,011	3mp 20 y 0 -
	Lewis P.	Scott					Far	nie T	. Gre	egg	
BE	19a. INFORMANT'S NAME (Type/Print)		19b. M	AILING ADDRESS	(Street	and Number or Rural					
2	Anthony J. Cando	eloro	26	Marta	Dri	ve - Wil				808	
	20e. METNOD OF DISPOSITION 1 Burlel 2 X Cremetion 3 Rem		emetery cremat	DATE OF DISPOS ory or other place)				17 20c. LC			
	4 □ Donation 5 □ Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	R.A. P	22.	NAME A	mpany	ACILITY				, FA
	- Daniel	& Nich		Hi 10	cks	Home for	r Fun	erals	, P.A Elktor	. MD	21921-5521
	23. PART i. Enter the diseases, or										Approximata
	ahock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CONCESTIVE INCENT FAILURE DUE TO (OR AS A CONSEQUENCE OF):										
7	ATRIAL FUBRILLATION										
CERTIFICATION	Sequentially list conditions, If any, leading to immediata cause. Enter INDERLYING CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
CA											
TE	that initiated events resulting in death) LAST d. ANTEMUSCUE IN TIC MADIUS/IS CULAR AT SEASE d. ANTEMUSCUE IN TIC MADIUS/IS CULAR AT SEASE										
HH	Toolsting in dividing Exist	d. HILLEM	OSCUL	= 120 11 C	4	TIMOLORI	ISCULAR BY SEASS				-
MEDICAL O	PERFORMED? AMA								VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE		
ED								20	Д		F DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	YES 🗆	NO B	UNCERTAL	N 🗆				
ZIA	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHERS.										
Sic	1 TES 2 NO	HOSPITAL: 1 Inpetient 2 ER/O	utpetient 3 🗆	DOA 4 Nur		na 5 🗆 Rasidence	8 🗆 Othe	r (Specify)			
Y PHYSICIAN:	27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO										
ED BY	2 Accident 3 Suicide 8 Could not be datarmined 4 Nomicide datarmined 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, term, street, factory, office City or Town, State)								ute Number,		
E	29a. CERTIFIER	M. OFFICIAL A.									
COMPLETED	298. CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
	29b. SIGNATURE AND TITLE OF CERTIFIER 29d.								29d. DAT	DATE SIGNED (Month, Day, Year)	
TO BE	Juliall.	lug-21.				DO 7	46	3	•		
F		RA.M.D.	118	NORTH	5	+ Suite	21	4. E	IKT	3N, 1	nd 21921
	OCT 20 1995	July a small	or Kardal	ll							

: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires	TO THE FUNERAL DIRECTOR: After this certificate has been sign be filed within 72 hours after death with the State Dept. of Heat	IMPORTANT: If Item 28 is marked, or Item 23 shows

ALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 7:54 Scul1 October 14 1995 ам Blanche Μ. . SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Yea 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 🗌 M 2 😾 F 90 YRS 178 - 07 - 56982, 1905 Pennsylvania June 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Calvert Manor Nursing Home Rising Sun Cecil RESIDENCE OF DECEDENT Maryland Pennsylvania 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY LIMITS? Cecil North East Delaware Media 1 YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 47 Timberlane Drive 21901 17 Wynmoor Road 19063 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. MARITAL STATUS 14. flACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: White BY 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 8 Homemaker Her own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilmer Marshall Daisy Ayers BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Janet B. Ward 47 Timberlane Drive, North East, MD 21901 20a. METHOD OF DISPOSITION
1

↑ Burlal 2 □ Cremation 3 □ Rer 20b. PLACE AND DATE OF DISPOSITION (Nama of OATE 20c. LOCATION - City or Town, State Edgewood Cemetery 10/18 Glen Mills, Penna. 4 Donation 5 Dether (Specify) 21. SIGNATURE OF FUNERAL BERVIOL 22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, MD 21901 23. PART I. Enter the diseases, or complications that caused the dealth Oo not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one cause on each lina. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final disesse or condition SEPSIS Tuk resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Dementia advanced Sinte CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury **OUE TO (OR AS A CONSEQUENCE OF):** that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO BED RIDBEN W COMPLETION OF CAUSE SEVENE 1 TYES 2 THO OF DEATH? CONTRACTURES 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHES:
4 Auraing Home 5 Rasidence 6 Other (Specify) 1 YES 2 NO 1 Inpetiant 2 ER/Outpetient 3 DOA 27. MANNER OF DEATN 28c. INJURY AT WORK? 28a. DATE OF INJURY 26b. TIME OF 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, term, street, lactory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND THE CONCERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 44102 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Renzulli, MD 901 Warburton Road, Elkton, MD 31. DATE FILED (Month), Day, Year)
OCT 1 7 1995 32. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, F.O. BOA 68181	BALIIMURE, IMARITANT
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	ath. Page 6 may be retained by the hos
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	neral director, page 5 should be detache
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitled at once.	iminer must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) Nora T.	Sanderson					DATE OF DEATH	1995	(EAB	TIME OF DEATH 3:25A M
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birtnday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	7. 0	DATE OF BIRTH	8.	BIRTHPLA Country)	CE (State or Foreign
	505-09-8973		32 YAS.	MONTHS DAYS	HOURS MIN	No	Month, Day, Year) DV 23 191	2	Nebra	aska
_	9a. FACILITY NAME (If not institution, give :	street and number)		9b. CITY, TOWN	OR LOCATION OF	DEATH		9c. COUNT	Y OF DEATI	1
DIRECTOR	301 Russell Aven	ue		Ga i	thersbu	rg		M	ontgo	mery
EC	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCA	TION				100	I. INSIDE CITY LIMITS?
	MD Mont	gomery		Gaithe	rsburg				1)	YES 2 NO
MAL	10a. STREET AND NUMBER			10	f. ZIP CODE			10g. CITIZE	N OF WHAT	COUNTRY?
FUNERAL	301 Russell Ave	-			2087	•				States
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D	2 NO	It yes, s	CENDENT OF HIS secify Cuben, Mex 2 NO Spe	ican, Pu	RIGIN? (Specify Yea lerto Rican, atc.)	or No—	Black, WI	American Indian, hita, atc. thite
	15. DECEDENT'S EDU (Specify only highest grade	ICATION completed)	18a. DECEDENT'S	USUAL OCCUPATI	ON ost of working		16b. KIND OF BUS	INESS/INDUS	STRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)	or or worlding					
COMPLETED	12		Account	ant	1		Sportin		ds	
	17. FATHER'S NAME (First, Middle, Last) Earl Tranmer						First, Middle, Melden : Romans	Sumame)		
8	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street			Number, City or Town	State Zin C	ode)	
임	Earlene S. Tayl	or	5807				hesda, N			817
	20a. METHOD OF DISPOSITION 1 Burlai 2 Cremation 3 Ram	201	. PLACE AND DATE	OF DISPOSITION (A				CATION — CI		
	4 L Donation 5 L Other (Specify)	M	illcrest	Memoria.	Garde	ns i	11/04/95	Annap	olis,	MD
	2 SIGNACURE OF FUNERAL SERVICE LI	I. Latu		147 [nd address of Ouke of	GIO	YJohn M. ucester S	Taylo St. Ar	r Fur mapo	neral Home lis, MD
	23. PART i. Enter the diseases, or	complications met ceuse List pniy pne ause pn s	d the deeth. Do I							Approximata
	iMMEDIATE CAUSE (Final disease or condition resulting in dasth)	a	CANCE	EL OI	E LU	N	6			Intervel Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
AL C	PART II. Other significent condition	ns contributing to death I	out not resulting	In the underlying	g cause givan	In Part	1. 24s. WAS AN			RE AUTOPSY FINDINGS
S	CHI	-, HTA	1 (UPU			PERFOR		co	MPLETION DF CAUSE DEATH?
PHYSICIAN: MEDIC							1			YES NO
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE O		ES NO [UNCERT	AIN [
CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one)					
IXS	1 TYES TO NO	1 Inpatient 2 ER/Out		Nursing Ho	ne 1 🗓 Residen	_				
BY PH	27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY 1 YES 2 NO 28. PLACE OF INJURY — At horger farm, street, tectory, office 281. LOCATION Jerrest and Number or Rural Ro									
ETED	3 Suicide 6 Could not be determined	building, etc. (Spe	pcify)	atreet, factory, on		1	City or lown, State)	na Number of	Hurar Hour	number,
COMPLET	(Check only one) 2 MEDICAL EXAMIN	the best of my known the best of examination								d manner as ateted.
TO BE	200 GIGNATURE AND TIMES CENTER	Wester	· ·	W	29c. LICENSE		- 1	29d. DATE :	SIGNED (MC	onth. Day, Your)
-	30. NAME AND ADDRESS OF REASON W								v	
	Elliott Goldstei	n, M.D. 9410		getown	Kd. Bet	nesc	da, MD 20	814 (301-8	397-8866)
	NOV 02 19	95 Si Shu	dear Randal	1						
		No.								DHMH-16 Rev 1/

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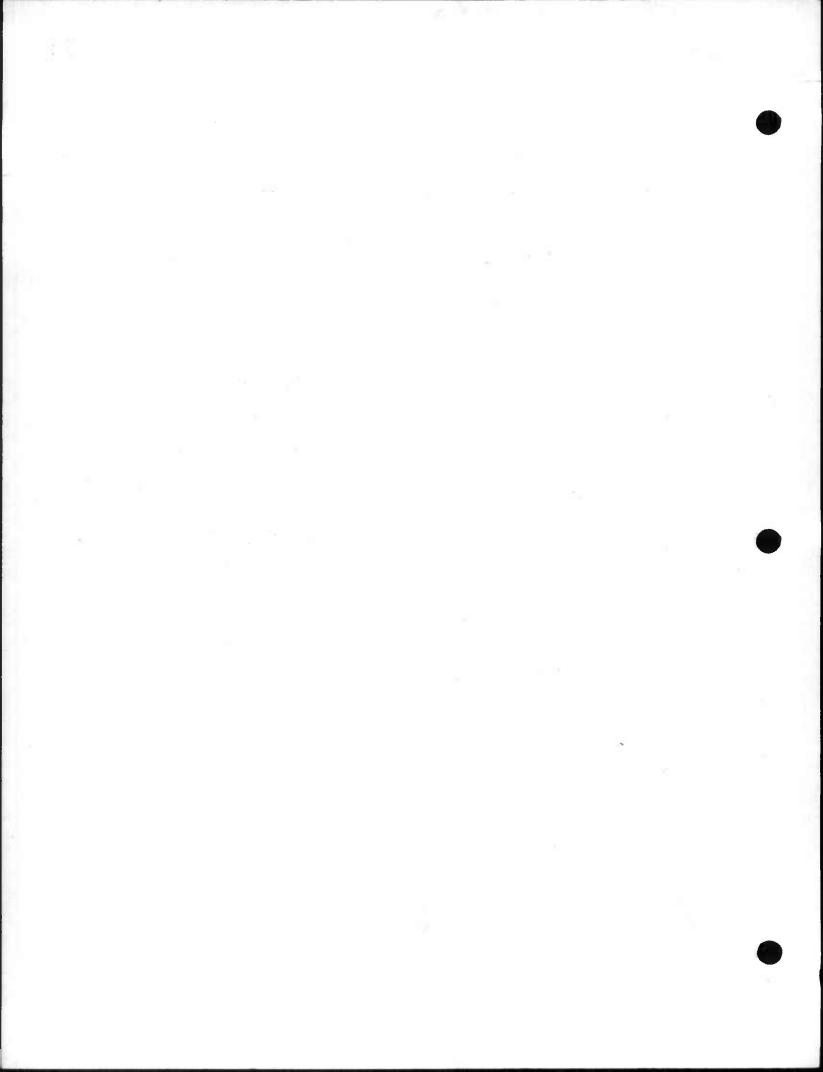
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		nedistrian				CE	HIIP	ICALI	= OF	DEA	H		REG. NO				
		1. DECEDENT'S NAME (First,		MDG									OF DEATH	AY	YEAR 3	. TIME OF DEATH	
		ALBERT 4. SOCIAL SECURITY NUMBER		AMES		HULTZ							ber 2	2, 19		3:45 A M	
				5. SEX	6. AGE (in yrs. lest	birthday)	IF UNDER	1 YEAR	IF UNDER	MIN.	(Montl	OF BIRTH		8. BIRTHPL Country)	ACE (State or Foreign	
should	1	441-12-1853 9e. FACILITY NAME (# not in:					THO.	Octobe			r 19			homa			
3 sh	œ							9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH						
6,	DIRECTOR	VAMC PERRY POINT						PERRY POINT Cecil									
ages	H.	10a. STATE	10b. COUNT	Υ			10c. CIT	Y, TOWN	OR LOCA	ATION					1	Od. INSIDE CITY	
permit. Pages 1,		Maryland		Cecil					Nor	th Ea	ıst				1	YES 2 X NO	
med 1	3AL	10e. STREET AND NUMBER							10	of. ZIP CODE				10g. CITIZ	EN OF WH	AT COUNTRY?	
an. ransi	FUNERAL	235 Old Far	mingt	T							219				ited	States	
ooko ng physician. he burlal-transit		11. MARITAL STATUS 1 ☐ Never Mented 2 ☑ Married 12. WAS DECEDENT EVER IN U. FORCES? 1 ☑ YES 2			2 NO	ED D	13.	WAS DE	CENDENT O	F HISPAI n, Maxica	NC ORIGIN	? (Specify Yes	or No-	14. RACE - Black, V	- American Indian, White, atc.		
	B	3 UNIdowed 4 Divorced US Army WWII							1 TYES	S 2 ⊠ NO	Specif	y:	Specify:			White	
attending se as the	유	15. DECI	EDENT'S EDU	CATION	MATI	16a, DEC	DECEDENT'S USUAL OCCUPATION			16b.	16b. KIND OF BUSINESS/INDUSTRY						
al or att		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			life. L	(Give kind of work done during most of working life. Do NOT use retired.) Warehouseman			g	US Gove		ernme	ernment Army				
the hospital or detached for u	COMPL	12			warenouseman .				Proving		Grou	Ground Facility					
the hor detach	8	17. FATHER'S NAME (First, MI					18. MOTHER'S NAME			ME (First, A	Aiddle, Maiden	Sumame)					
ad by the	띪	Henry Schu										Kola					
s retained 5 should notified	٩	19a. INFORMANT'S NAME (7)											per, City or Tow				
- 2 2 0		Ruth L. Sch									Roa		orth 1			21901	
		1 ☑ Burial 2 ☐ Crematio	n 3 🗆 Rem	oval from Stata	ceme	PLACE AN	atory or of	ther place)				1 O fO		CATION — C	•		
	1	4 Donation 5 Other (Specify) Oak 21. SIGNATURE OF FUNERAL SERVICE CICENSES					ove Baptist Cemetery 10/25 Bel Air, Maryland 22. NAME AND ADDRESS OF FACILITY Crouch Funeral HOme						yland				
death. Pag tuneral dii I. examiner	1	1/1/19	11	Chara	6			- 1									
irs after do n by the f removal.	Н	127 South Main Street, North East, MD 21901															
in a		23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, abook, or heart failure. List only one ceuse on each line. Approximate interval Between															
10 mg		iMMEDIATE CAUSE (Fin disease or condition	mi	Deep out						. ,						Onset and Death	
completely fille completely fille rial, cremation, c event, the		esulting in death) Prostate Cancer with Metastasis Due to (or as a consequence or):									3 Years						
D 0 = 0	_		_	Pneumo		CONSECU	JENUE OF	7.								2 87-1-	
te be execut sician and c prior to buria traumatic	CATION	Sequentielly list condition if any, leading to immediate			(OR AS A	CONSEQU	JENCE OF	7:								2 Weeks	
1 6 2 -	S	Cause. Enter UNDERLYING CAUSE (Disease or Injury															
	RTIF	that initiated events resulting in death) LAST		DUE TO	(OR AS A	CONSEQU	JENCE OF	7:									
E 8 - 0	ш	d															
Me Me	L C	PART if. Other aignificer	nt condition	a contributing to	death bu	ut not re	suiting i	n the un	derlyin	ng cause g	iven in	Part i.	24a. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS	
= 6 = -	DICAL										PERFORMED?			MILABLE PRIOR TO OMPLETION OF CAUSE			
Sign Heal	ш												_ [F OEATH?		
he law requires been a Dept. of h	AN: W	DID TOBACCO US	SE CONT	RIBUTE TO CA	USE OI	F DEAT	H YE	S 🔲 I	10 E	UNC	ERTAIN	10			1	YES 2 NO	
ATTENDING PHYSICIAN: The law requestrop. After this certificate has been a safer death with the State Dept. of 1.28 is marked, or item 23 sho	CIA	25. WAS CASE REFERRED TO EXAMINER?				26. PLACE		H (Check	only one)								
SICIAN: The certificate the State	PHYSICI	1 TYES 2 NO		HOSPITAL: 1 Inpetient 2	ER/Outpa	etlant 3 [DOA	OTHER 44 Nun	t; ing Hon	ne 5 🗆 Re	sidence	8 🗆 Other	(Specify)				
PHYSIC this ce with th	표	27. MANNER OF DEATH 1 ☒ Netural 5 ☐ F	Pending	28e. DATE OF (Month, D.			28b. TIME INJ	E OF URY	28c. INJ WC	JURY AT ORK?		28d. DE\$	CRIBE HOW I	NJURY OCCI	JRED		
DING PHYS After this death with	BY		Investigation					М		YES 2	NO						
TTENDI TOR: A after d			Could not be	28a. PLACE O building,	etc. (Speci	— At hom ffy)	e, ferm, a	treet, fact	ory, offic	ca		28f. LOCA	TION (Street a or Town, State)	nd Number o	or Rural Rout	ne Number,	
OR ATTEN DIRECTOR: hours after Item 28 Is		29a, CERTIFIER					-	_									
7 70 =	P	(Check only		CIAN: To the best of													
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	COMPLET	2 MEDIC		R: On the basis of a	cemination	and/or Im	veatigation	n, In my o	pinion, d	death occur	ed at the	time, data	and place, an	d dua to the	ceuse(s) ar	nd manner as stated.	
THE F	BE	296. SIGNATURE AND TIPLE	OF CENTURE	-1	In					29c. LICE				29d. DATE	SIGNED (M	onth, Dgy, Year)	
5 5 3 W	6	1. 17.	Mis	mag 1	NO					D4	2800)		> /	10/22/85		
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS A. BIONDO, M.D. VAMC, PERRY POINT, PERRY POINT, MD 21902															
		31. DATE FILEO (Month, Day,)		, M.D.			CKKY	POI	TAT.	PERR	X PC	TNT,		21902			
		OCT 24	1995	Julia d'Aux			1										
l l		00164	1000	Java was	Mank .	WOUL.	V										

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Midple, Last) 3. TIME OF OEATH 40 2. DATE OF DEATH FarNett Char Sweel October 1995 125 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
Feb. 16,1919 5. SEX 8. BIRTHPLACE (State or Foreig 225-18-9994 Virginia HOURS 1 M 2 F 76 YRS. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harford Memorial Hospital DIRECTOR Havre de Grace Harford RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Cecil Perryville 1 TES 2 NO use as the burial-transit permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 1375 Principio Furnace Road 21903 U.S.A. ay be retained by the hospital or attending physician. page 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried It yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced W.W. II White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest V.A. Medical Center Eleven Years College (1-4 or 5+) Perry Point, Maryland Operating Engineer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme) Charles Sweet to Myrtle Sweet BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Catherine N. Sweet 1375 Principio Furnace Rd., Perryville, MD 21903 hours after death. Page 6 may be 99 20a, METHOD OF DISPOSITION
1 Si Buriel 2 Cremation 3 Re
4 Donation 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must funeral director, Harford Memorial Gardens 10/24/\$5 Aberdeen, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home DC Perryville, Maryland 21903 filled in by the event, the medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximsta shock, or heart fallure. Liet only one cause on each line interval Between cremation, or IMMEDIATE CAUSE (Final Onset and Death howel. diseese or condition resulting in death) the attending physician and completely i Mental Hygiene prior to burial, crematic DIVISION OF VITAL RECORDS, P.O. BOX 68760 other traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or Injury DUE TO (O S A CONSEQUENCE OF) thet initieted eventa reaulting in deeth) LAST 5 signed by the a Health and Men PART II. Other aignificant conditions contributing to death but not regulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS Ohmunr Ummu AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 - YES 2 NO 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN N has be Dept. u PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem certificate h EXAMINER? OTHER patient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 27. MANNER OF DEATH 28c. INJURY AT WORK? DATE OF INJURY 26b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED this c marked, Netural 5 Pending BY 1 YES 2 NO After Investigation 2 Accident OIRECTOR: Aff hours after de-item 28 is n 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide PLACE OF INJURY — At home, ferm, street, tectory, office building, atc. (Specify) 8 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL OR ATTO THE FUNERAL OIRECT DE filed within 72 hours at IMPORTANT: If Item 2 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner ee stated. MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner se stated 29b. SIGNATU AND JITLE OF CERTIFIES 29d. DATE SIGNED (Month, Dev. Year) BE WWI 2 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Tyr 0) 32. MEGISTRAN'S SIGNATURES

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

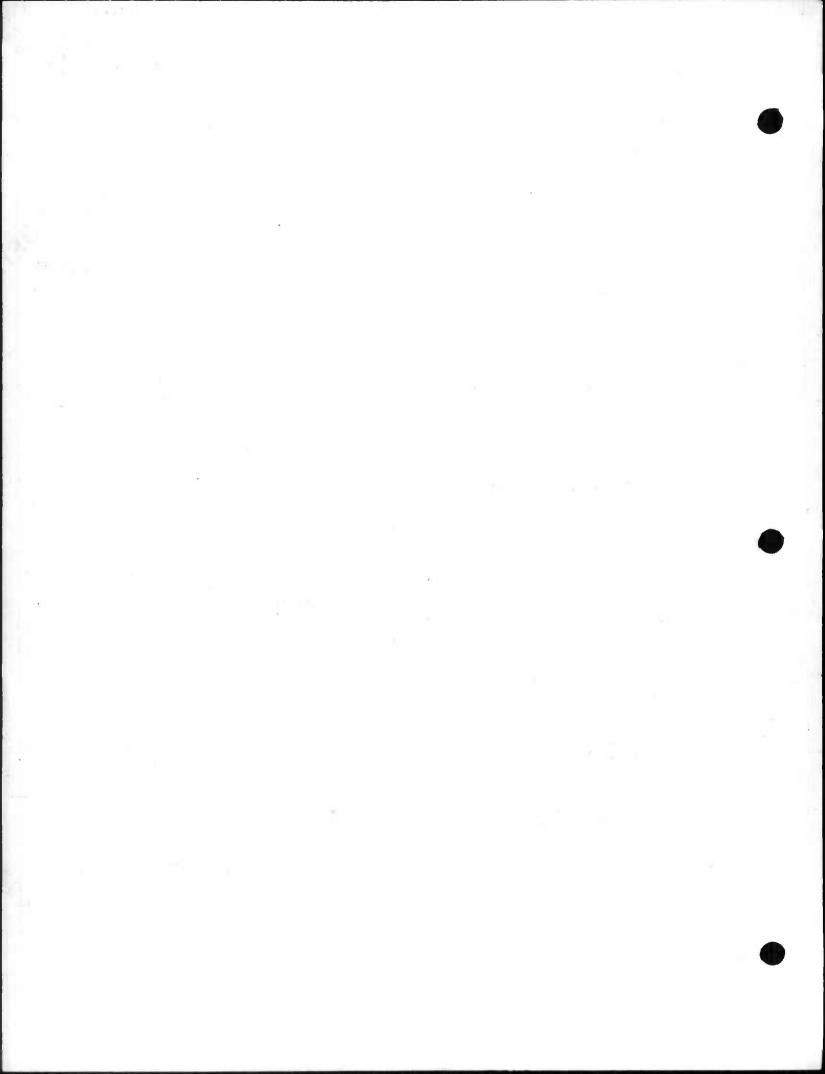
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
SISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Leat)					2. DATE OF DEATH		3. TIME OF DEATH				
	RONNIE C. SMALLW	OOD			OCTOBER 2	7:40am м						
	016 00 0040	CVA. III. CO. CO.	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. BIRT	BIRTHPLACE (State or Foreign Country)				
		₩ 2 □ F			June 24,19		ginia					
<u>a</u>	9e. FACILITY NAME (If not institution, give street				R LOCATION OF DI		9c. COUNTY OF	DEATH				
01.	Washington Advent:	ist Hospita.		TAKOMA	PARK, MA	ARYLAND	MONTGO	MERY				
REC	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION		10d. INSIDE CITY					
٥	Maryland Montgor	nery	Si	lver Sp				1-X YES 2 NO				
FUNERAL DIRECTOR	10e. STREET AND NUMBER	#100		101	, ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
R	5 Manchester Place	# 1U3	II.C. ADMICO	140 1400 000	20901		US					
표	1 Never Married 2 Married	FORCES? 1 YES	If yes, spe	ecify Cuban, Mexica 2 M NO Specifi	NC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	Blac	RACE — American Indien, Black, White, etc.					
ВУ	3 Widowed 4 Divorced	res, are remon pr		I I I TES	Z NO Specin	γ.	Spec	White				
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION npleted)	16e. DECEDENT'S U	ork done during mo		16b. KIND OF BUS	SINESS/INDUSTRY					
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use									
N N	17. FATHER'S NAME (First, Middle, Last)	3	Mainten	ance En		Apartn ME (First, Middle, Malden	ent Comp	lex				
	Unknown						Surname)	ime)				
) BE	19e. INFORMANT'S NAME (Type/Print)	Officiowif										
5	Diana Smallwood							g, MD 20901				
	20e. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 □ Removal	from State 20b.	PLACE AND DATE OF	DISPOSITION (Na	me of	DATE 20c. LO	CATION — City or T	own, State				
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS		te of He		metery 1		Silver Spring, MD					
	14 00	5_ (/				llins Fune	ral Home	. Inc.				
	Jum ()	and		500 บ	niversit	y Blvd.W.	Sil.Spr.	MD 20901				
	23. PART i. Enter the diseeses, or com ahock, or heart failure. List	ipiicationa that caused t only one ceuse on ee	the death. Do no ch line,	t enter the mo	de of dying, auc	h as cardiac or reapi	ratory arreet,	Approximate interval Between				
	immediate cause (Fine) disease or condition regulation in death) Omnoble											
	reading in death)											
z	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (DISEASE											
AT I	oue to (or as a consequence of): If any, leading to immediate cause. Enter UNDERLYING OUE TO (or as a consequence of): Details the consequence of the consequence of the cause. Enter UNDERLYING											
FIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	1800 (5)				2009)				
CERTIFICATION	reaulting in death) LAST							İ				
- 4	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 244 MS AN AUTOPS.											
CAL	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS ANALIBLE PRIOR TO COMPLETION OF CAUSE											
MEDIC	nonal Zai	Que	3			1 - YES 2	No	OMPLETION OF CAUSE OF GEATH?				
	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	NO D	UNCERTAIN	<u>-</u>		1 TYES 2 NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	/ 3	6. PLACE OF DEATH		0110210711	, , ,						
YSIC	1 TES 2 NO 1	OSPITAL: Inpatient 2 - ER/Outpa		OTHER: Nursing Home	5 🗆 Residence	8 Other (Specify)						
H H	27. MANNER OF OEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		JRY AT RK?	28d. DESCRIBE HOW INJURY OCCURED						
BY	2 Accident Investigation	M 1 VES 2 N 28e. PLACE OF INJURY — At home, ferm, street, factory, office										
8	3 Suicide 6 Could not be 4 Homickie determined	building, atc. (Specia	y)	eet, ractory, omice	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
91	290. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my knowle	idea ideath consum d	at the time date			-					
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: 0							end menner as stated.				
E C	29b. SIGNATURE AND TITLE OF CONTINUES	1			29c. LICENSE NUN		29d, DATE SIGNE					
œ		Willing	7		D-30	5927	· 10/:	128/ 1agr				
5	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, F	1104	SPFir	g Street =	#201 5	luer spring				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA										
	QCT 3 0 1995	Jalia Davidson	Kardall									



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409-50-2006 61 1 🗆 M 2 📈 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATIO DIRECTOR Washington Adventist Hospital Takoma Park RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 0c. CITY, TOWN OR LOCATION Prince Georges Takoma Park Maryland permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 7309 Trescott Ave. the funeral director, page 5 should be detached for use as the burial-transit 20 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF FORCES? 1 YES 2 1 Never Married 2 Married Il yes, specify Cuba 1 - YES 2XXNO BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Nurse/Supervisor 17. FATHER'S NAME (First, Middle, Last) 16. MOTHE F Herbert Phillips He BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number of 2 7309 Trescott Ave. Flovd W. Shanko 99 20a METHOD OF DISPOSITION
1 A Burlal 2 Cremation 3 R 20b. PLACE AND DATE OF DISPOSITION (Name of must Fairview Cemetery Oct □ Donation 5 □ Other (Specify) medical examiner MATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS hours after death. 254 Carroll signed by the attending physician and completely filled in by Health and Mental Hyglene prior to burial, cremation, or remo 23. PART i. Enter the d seases, or complications that caused the deeth. Do not enter the mode of dying eart failure. List only one ceuse on each line. IMMEDIATE CAUSE Winei the diseese or condition Acute Lymphocytic Leukemia reauiting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): executed Idiopathic Thrombocytopathic P CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the death certificate be cause. Enter UNDERLYING Cirrhosis of the Liver CAUSE (Disease or injury other that initiated eventa resulting in daeth) LAST Diabetes Mellites 0 PART il. Other aignificant conditions contributing to daeth but not resulting in the underlying cause gire MEDICAL that any Obesity has been Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO [2] PHYSICIAN: MP 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The r this certificate h Item **EXAMINER?** HOSPITAL: 1 - YES 2 NO PHYSICIAN: 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH marked, 28b. TIME OF 28c. INJURY AT WORK? INJURY 1 🔀 Natural 1 YES 2 DIRECTOR: After the hours after death v BY OR ATTENDING 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide COMPLETED 6 Could not be 4 Homickie 28 item 29e. CERTIFIER
(Check only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, a FUNERAL within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred TO THE HOSPITA
TO THE FUNERA
DE filed within 7
IMPORTANT: I 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICEN B D10 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Roy H. Sandstrom, 7701 Carroll Ave. Takoma M.D.

32. BEGISTRAR'S SIGNATURE

Julia Davidson Roydell

Shanko

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Carol

4. SOCIAL SECURITY NUMBER

31. DATE FILED (Month, Day, Year)

OCT

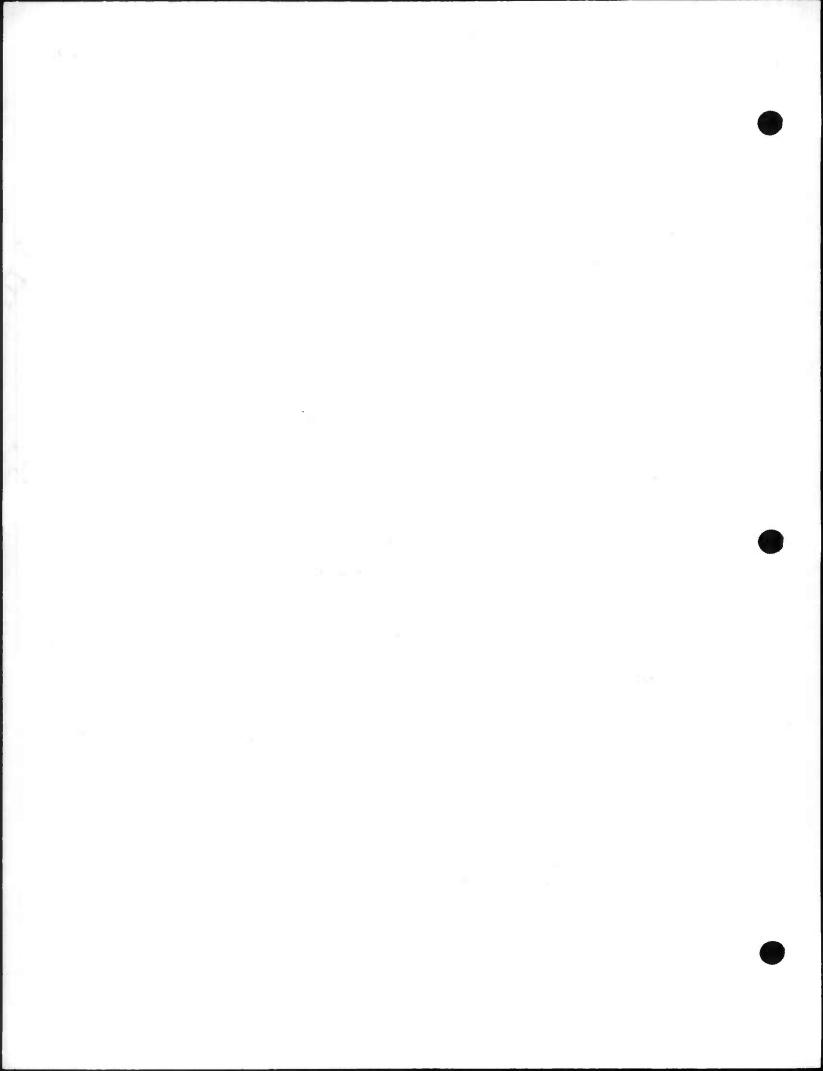
30 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH

6. AGE (in yrs. last birthday)

95 34536

								20	•		-
				DEAT		MENTA	NL HYGIEN				
							of DEATH Ober 2	4,199	95 ^{EAR}		OF DEATH
In the state of th					7. DATE OF BIRTH 6. BIRTHPLACE (Sh. November 3, 1933 Tennes					State or Foreign	
96. CITY, TOWN OR LOCATION OF DE Takoma Park						eath 8c. country of Deat Montgomer					
	10c. CIT	Y TOWN	OR LOCAT	TION						104 101	NDE OUTV
			Par	k						1 X YE	S 2 NO
					912			U.S	S.A.	VHAT CO	UNTRY?
ARN ON	IED O	13.	Il yes, sp	ENDENT Control 2 X NO	n, Maxica	n, Puarto	N? (Specify Ye Rican, etc.)	a or No—	14. RACE Black Speci	c, White,⊹ /y:	nite
(Gh	EDENT'S to kind of v Do NOT us	vork done	during mo	ON Isl of workin	g	16	b. KIND OF BU	SINESS/INI	DUSTRY		
Nu:	cse/S	Supe	rvis	or		H	ospita	1			
					elen		Middle, Maldan rtner	Sumame)			
							Park,)	
CEA	NDDATE	OF DISPO	SITION /Na	me of		DAT	95 Gre	CATION -	City or To	wn. State	
		22.	NAME AN	D ADDRES	S OF FAC	T YTLIE	akoma Washi	Fune:	ral F	Iome	Inc.
line.		ot enter		da of dyi			diec or resp		•	Ap int Or	proximeta larvai Between liset and Daath
	JENCE OF		, carta							-	days
	COMPCE OF		opat.	hic I	Purp	ıra				2	years
SEO	he I	Live	r							u	nknown
115	ites									10	years
ot re	sulting i	n tha u	ndariying	g causa g	ivan in	Part I.	24a. WAS AN PERFOR	RMED?	24b.	AVAILABL	TOPSY FINDINGS LE PRIOR TO TION OF CAUSE H?
EAT	H YE	s 🗆	NO 🔯	UNC	ERTAIN	- I				1 YE	S 2 🗌 NO
LACE	OF DEAT	H (Check									
3 [DOA	4 🗆 Nur	sing Hom	e 5 🗆 Re	aldence						
	28b. TIMI		28c. INJI WO 1 _ Y	RK?	NO	28d. DE	SCRIBE HOW I	NJURY OC	CURED		
hom	e, farm, s	treet, fac	tory, office			28f. LOC City	CATION (Street or Town, State)	and Number	or Rurel A	oute Num	ber,
							use(s) and mar and place, an			and mer	mer as stated.
				29c. LICE					E SIGNED		
					298	oun.					4,1995
	27) (Type,		e. T	akoma	a Pai	rk.	MD 209	12			



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND / I	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CE	RTIFICATE	OF DEAT	ГН		REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIENE REG. NO.	Ē				
	1. DECEDENT'S NAME (First, Middle, Lest)	Frederick	5	teppe		2. DATE OF DEATH MONTH DAY					
	4. SOCIAL SECURITY NUMBER 248-36-1121 9a. FACILITY NAME (If not institution, give	1 X M 2 □ F 6	(in yrs. lest birthdey) YRS.	IF UNDER 1 YEAR MONTHS DAYS 9b. CITY, TOWN	7. DATE OF BIRTH (Month, Day, Year) July 7, 19 ATH	Co	RTHPLACE (State or Foreign unitry) Outh Carolina F DEATH				
FOR	Holy Cross Hospi	tal		Silv	er Spring	3	Mont	gomery			
DIRECTOR	100. STATE 10b. COUNT	orry	10c. CIT	Myrtle				10d, INSIDE CITY LIMITS? 1 YES 2 X NO			
RAL	10s. STREET AND NUMBER			10	I. ZIP COOE		10g. CITIZEN OF WHAT COUNTRY?				
BY FUNERAL	309 South Lake 11. MARITAL STATUS 1 Never Merried 2 M Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR O WORLD WAY	2 NO	It yes, s		IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No — 14. R	d States ACE — American Indian, liack, White, etc. pecify: White			
COMPLETED	15. DECEDENT'S EO (Specify only highest grad Elementary/Secondary (0-12)	DUCATION de completed) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of life. Do NOT u	B USUAL OCCUPATE work done during m use retired.)	ost of working	16b. KINO OF BUS		N.			
COMP	17. FATHER'S NAME (First, Middle, Last) Jack Thomas Ste	2 Poppe	Traini	ng Offic	18. MOTHER'S NAI	United ME (First, Middle, Meiden : Tenkins		Government			
TO BE	190. INFORMANT'S NAME (Type/Print) Jean G. Steppe	·PPC			and Number or Rural F	Route Number, City or Town		293/2			
	20e. METHOD OF DISPOSITION 1 & Burles 2 Cremetton 3 Removal from State 4 Densition 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of commetcy, cremetory or other piecest. Michael's Oct.30 Lake Murray, South Carolina										
	21, SIGNATURE OF FUNERAL SERVICE L	nc Mulling	aupend	Rober Rockv Avenu	t A. Pump ille, Inc e, Rockvi	ohrey Funer 300 West	cal Hom Montg Land 20	e/ omery 850-2805			
NOI	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Commod Column Colu										
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in cleath) LAST d.										
MEDICAL	PERFORMED? 1 VES 2 NO							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL CASE OF DEATH (Check only one) EXAMINER? OTHER:										
BY PHYS	1 VES 2 NO 27. MANNER OF CEATH 1 Natural 5 Pending Accident Investigation	1) Inpetient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year)	28b. TI	ME OF 28c. IN	JURY AT ORK? YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURE	0			
	3 Suicide 8 Could not b 4 Homicide determined	28e. PLACE OF INJUR building, atc. (Sp	ty — At home, term, ecify)	street, factory, offi	00	281. LOCATION (Street e City or Town, State)	and Number or Ru	aral Route Number,			
COMPLETED	onel only	rSICIAN: To the best of my kno NER: On the beele of examinat						uso(e) and mannar so stated.			
TO BE	296. SIGNATURE AND TITLE OF CERTIF	che m		on. Print)		969	> Octo	iker 27, 1985			
	11 11 4 101	ing. InD, 9	707 /7ed	diral cer	te Dr.	suite 320,	Rockvil	le, mp 20850			
	NOV 01 1995	Juli Bavelson K	indall								

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

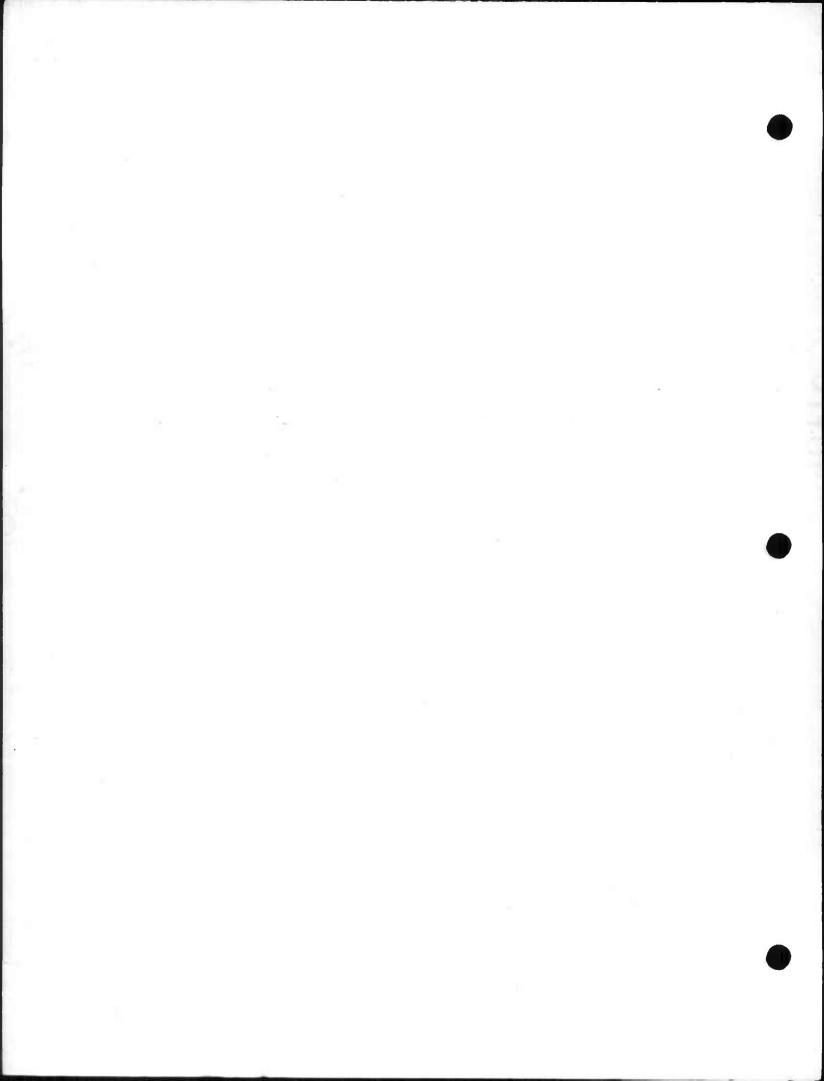
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First, Middle, Last) ELSE IDA SHYBURGH								October 30, 1995			995 ^R	3:05 P M	
	4. SOCIAL SECURITY NUMB	IER	5. SEX	8. AGE (In yrs. la:		IF UNDER 1		IF UNDER 24 HRS.	7. DATE OF E	ACTAL			PLACE (State or Foreign	
	435-34-8886									Dec. 30, 1908 Ge			many	
	9s. FACILITY NAME (If not in		,		3			R LOCATION OF DE			9c. COU	NTY OF D	EATH	
DIMECTOR		Bedford Court Health Center				S	ilv	er Spring	g		Mo	ontgo	omery	
#	10a. STATE	10b. COUNTY			10c. CITY,							T	10d. INSIDE CITY LIMITS?	
5	Maryland					-	er Spring	g				1 YES 2 NO		
BY FUNERAL		3700 International Drive					101	. ZIP CODE 2091	06				States	
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AI	RMED				PANIC ORIGIN? (Specify Yes or No — 14. RAC				- American Indian,	
٦	1 Never Married 2 3 N Widowed 4 Divo		IF YES, GIVE W	AR OR DATES	NO			2 X NO Specify						
ב ב		EDENT'S EDUC	CATION	18a. Di	ECEDENT'S U	SUAL OCC	HIPATIC	DN .	16h KIN	D OF BUS	INESS/INC	VICTOV	White	
		highest grade		(C	alve kind of wo a. Do NOT use	rk done du	ring mo	st of working	Too. Kill	0 01 000	11112371112	, o o i n i		
COMPL			2	<i>'</i>	homei	nake	r		01	vn H	ome			
5	17. FATHER'S NAME (First, Mi	iddle, Last)						18. MOTHER'S NAI	ME (First, Middle	e, Maiden	Surname)			
n n	Heinrich				hschi]			Helena					ornberger	
2	Peter Shy		(3	Son)				nd Number or Rural F de Road	Richi				229	
	20a. METHOD OF DISPOSITI	ION on 3 🗆 Remo	oval from Stata	20b. PLACE	AND DATE OF	DISPOSIT	ION (Na	me of	DATE	20c. LO	CATION —	City or To	wn, State	
	4 Donation 5 Dother		THEFT	Ches	apeak	e Cr	ema	tory, Ind	10-31	Be	ltsvi	ille,	MD	
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE			22. N	app	Funeral	Servi	ces				
	(en)	Hens	Luton										MD 20910	
	23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	eart failure.	e. STI	OKE	b.		he mo	de of dylng, suct	n ss cardiac	or respl	ratory sm	rest,	Approximate interval Between Onset end Death	
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
1	PART II. Other significe	nt condition	s contributing to	death but not	resulting in	the und	erlyln	g cause givan in	Pert I. 24s		AUTOPSY	24b.	WERE AUTOPSY FINDINGS	
MEDICAL			SORPER						1	PERFOR			AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
ME	ATHER	OSCLE	ROTIC HE	TOTAL	DISET	155	<u> </u>				• •		1 TYES 2 NO	
2	DID TOBACCO U		RIBUTE TO CA] UNCERTAIN	1 🗆 📗					
3	25. WAS CASE REFERRED TO EXAMINER? 1 TYES 2 X NO	D MEDICAL	HOSPITAL:		CE OF DEATH	OTHER:								
	27. MANNER OF DEATH		1 Inpatient 2	INJURY	28b. TIME	OF 2	8c. INJ	e 5 Residence	8 U Other (Sp 28d. DESCRI		NJURY OC	CURED		
BY PHYSICIAN:		Pending Investigation	(Month, D	lay, Year)	INJU	RY M		RK? YES 2 NO						
	3 Suicide 8	Could not be	28e. PLACE O building,	F INJURY — At he etc. (Specify)	ome, farm, str	eet, fector	ry, offic	•	28f. LOCATIO City or To	N (Street a wn, State)	nd Number	or Rural F	Route Number,	
	200 CERTIFIER 14													
COMPLEIED	(Check only							and place, and due eath occured at the) and manner as steted.	
	29 PORIGNATURE AND TITLE	AF CERTIFIER	1					29c. LICENSE NUN	IBER		29d. DAT	E SIGNED	(Month, Day, Year)	
0 25	Chun S. 7	Mado	uana, t	40				D3914	6) (Oct.	31, 1995	
	Alvin S. Ma						ve.	, #1248	Chev	y Ch	ase,	MD 2	20815	
	31. DATE FILED (Month, Day.	Money		D'S CICNATURE										
	NOV OT	733	my wood										DHMH.18 Bay 1/8	



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	LINDA	A.	SCHULER			OCT. 29		1:02 P M		
	4. SOCIAL SECURITY NUMBER		MO	UNDER 1 YEAR	THPLACE (State or Foreign					
	213-76-7725	1 🗆 M 2 📡 F	40 YRS.			JUNE 30,19		MASH. D.C.		
æ	9e. FACILITY NAME (If not institution, give :		96		R LOCATION OF DEA		9c. COUNTY OF			
DIRECTOR	HOLY CROSS HO	SPITAL		SILVI	ER SPRING		MON	GOMERY		
REC	10e. STATE 10b. COUNT	Y	10c. CITY, TO	OWN OR LOCAT	TION			10d. INSIDE CITY		
		MONTGOMERY					1 X YES 2 NO			
3AL	100. STREET AND NUMBER			100	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	1503 GLEASON				20902			S.A.		
	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)						or No— 14. RA Bit	CE — American Indien, ack, White, etc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE WAF	OR DATES	1 🗌 YES	2 NO Specify:		Sp	white		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	(CATION	16a. DECEDENT'S USU (Give kind of work	IAL OCCUPATION	ON et et weet/ee	16b. KIND OF BUS	INESS/INDUSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use rei	tired.)	st or working					
MP	12		CLERI	K				CATE GOV'T.		
	17. FATHER'S NAME (First, Middle, Last)	Linguina				E (First, Middle, Maiden S				
BE	GENE 196. INFORMANT'S NAME (Type/Print)	WHITTE	10h MAII INC AOI	DBECO (011		RTHA oute Number, City or Town	WELLS			
2		CHULER	SAME		TEM #10	ute number, City or lown	, Stare, Zip Code)			
	20a, METHOD OF DISPOSITION		20b. PLACE AND DATE OF DE			OATE 20c. LOC	ATION — City or	Town. State		
	1 Burlel 2 M Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	CHAMBERS CI	placel		1,	RIVERDAL			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			D ADDRESS OF FACI		C. VIII WALL	111		
	10/08/16	meres	al Monoga	LI LI	CHAMDEDG	CO TNG	CTITUD	20910 SPRING, MD.		
	23. PART I. Enter the diseases, or	complications that c	aused the death. Do not e	entar the mo	de of dying, such	as cardiac or respir	atory arrest.	Approximata		
	IMMEDIATE CAUSE (Clos)	List only one cause	on each line.					Interval Between Onset and Death		
	disease or condition resulting in death)	ADULT	RESPIRATOR RAS A CONSEQUENCE OF:	2) (1) (1)	Tress.	Sychology	W = t3	1/100		
	,			/		1		1,700		
20	Sequentially list conditions,	6. PANCE	RAS A CONSEQUENCE OF):					Imo		
AT	If any, leeding to immediate cause. Enter UNDERLYING	Ca /0%	R AS A CONSEQUENCE OF);					5unc		
밀	CAUSE (Disease or Injury that Initiated events	OUE TO (O	R AS A CONSEQUENCE OF):					3 //-		
CERTIFICATION	resulting in deeth) LAST	d								
	PART II. Other algnificent condition	as contributing to de	eth but not resulting in th	e underlulne	cours alves in D		umanau I.a			
CAL	FundeniA		out for faculting in the	re underlying	ceuse given in Pa	PERFORM	WED?	No. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC	7					1 YES 2	X NO	DF DEATH?		
	DID TOBACCO USE CONT	RIBLITE TO CALL	SE OF DEATH YES	□ NO K	UNCERTAIN	_		1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	LIBOTE TO CAO	26. PLACE OF DEATH (C		ONCERIAIN					
SIC	EXAMINER?	HOSPITAL:		HER: Nursing Home	5 Residence 8	Other (Specify)				
	27. MANNER OF OEATH	28e. DATE OF IN. (Month, Day,	JURY 28b, TIME OF		JRY AT	28d. DESCRIBE HOW IN	JURY OCCURED			
BY	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO					
	3 Suicide 8 Could not be determined	28e. PLACE OF II building, etc	NJURY — At home, term, street (Specify)	t, fectory, office	2	28t. LOCATION (Street en City or Town, State)	nd Number or Rura	Route Number,		
COMPLETED										
MPL	29e. CERTIFIER (Check only one)	C/AN: To the best of my	knowledge, death occurred at	the time, date	end place, end due to	the cause(e) and menn	ner as stated.			
Ö			nination end/or investigation, in	my opinion, de	isth occured at the tir	me, date and place, end	due to the cause	(6) end menner es stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER	. //	11 %		29c. LICENSE NUMB	ER	/	(Monthy Day, Year)		
P	30. NAME AND AODRESS OF PERSON WH	O COMPLETE CALLE	OF DEATH (ITEM 27 CT	0	2067	7	10/2	18/85		
	Stenben A	tellian 1	1/ 1/1/ 67	40 1	autrose	R/ F	Jack	le 20852		
	31. OATE FILED (Month, Dey, Year)	32. REGISTRAR'S	SIGNATURE	10 101	01011036	110,1	ock VI	IE XUOUZ		
	OCT 31 1995	Julia David	ion Randall			,				

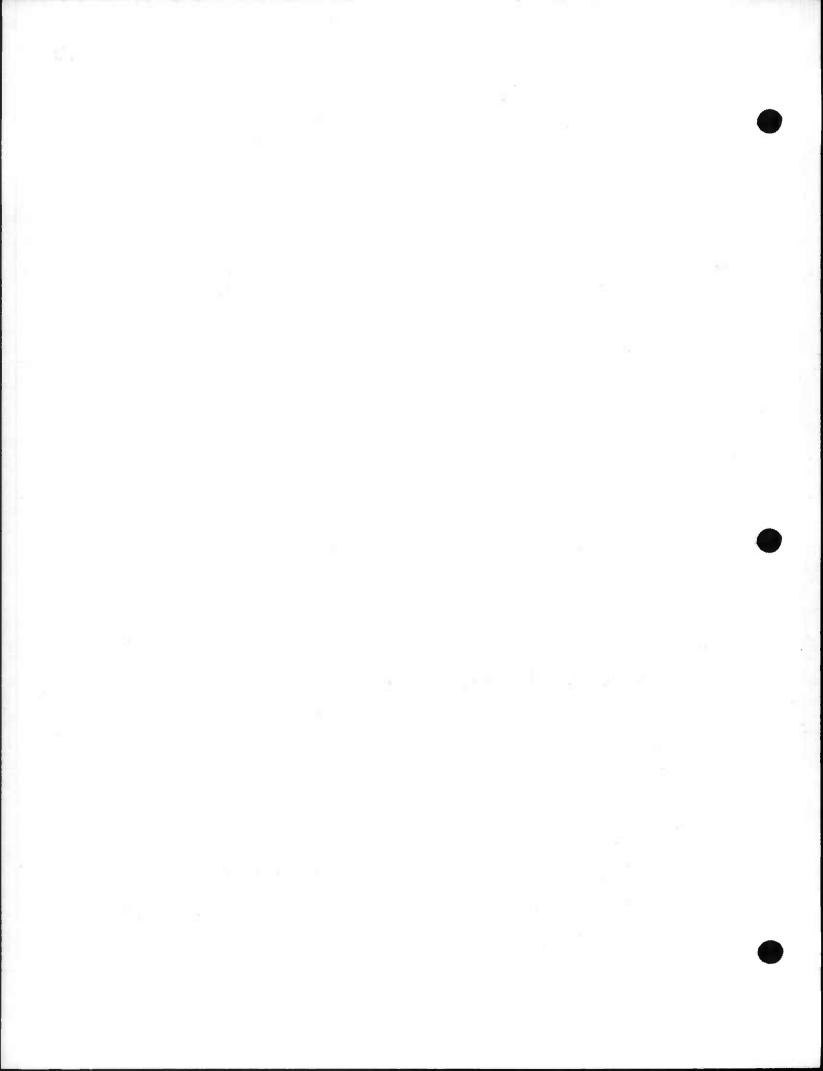
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FOR STATE REGISTRAR DUPLICATE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 FRANCES SPAHR October MARCELLA 2:36 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH April 0 16, 1925 389-20-0803 HOURS 70 1 - M 2 XX Wisconsin YRS. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington Adventist Hospital DIRECTOR Takoma Park MONTGOMERY RESIDENCE OF DECEDENT Maryland 10c. CITY, TOWN OR LOCATION Prince George's 10d. INSIDE CITY Adelphi 1 TYES 2 XXNO permit. FUNERAL 10s. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3210 Powder Mill Road n by the funeral director, page 5 should be detached for use as the burial-transit removal. 20783 United States the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yee, specify Cuban, Mexican, Puerto Ricen, etc.)

1 YES NO Specify: Duplical 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY Specify: White XX Widowed 4 □ Divorced 16a. DECEDENT'S USUAL OCCUPATION
172-hon kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Floral Designer Florist 17. FATHER'S NAME (First, Middle, Last)
Karl Meinrod 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Frances Bridget Fakler Lynch F Page 6 may be retained by BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Timothy Spahr 11233 B Slalom Lane Columbia, Maryland 21044 pe 20a. METHOD OF DISPOSITION

1
Burlal 24 Cremetton 3
Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Metropolitan Crematory 10/28/95 Alexandria, Virginia 6 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md.20705 hours after death. medical 23. PART I. Enter the diseases, or and completely filled in by burial, cremation, or remo complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death executed within 24 | the disease or condition MYDCARDIAL INFARCTION reaulting in death) MR event. DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): 9 if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to 2 CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 death o PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. requires that the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by ti DIABETES Mellitus, hypertension AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TYES 2 XXIO Shows 1 TYES XX NO has been Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN IN PHYSICIAN: W. AND CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Hem certificate h TX YES 2 NO 3 DOA 4 Nursin HOSPITAL PHYSICIAN: 1 Inpatient 2 ER/Outpatient ng Home 5 - Residence 6 - Other (Specify) 0 26a. DATE OF INJURY (Month, Day, Year) MER OF DEATH 26d. DESCRIBE HOW INJURY OCCURED this c marked, 28b. TIME OF 28c. INJURY AT WORK? t X Natural 1 YES 2XXNO After the BY 2 Accident ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 90 3 Sutoide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: hours after COMPLETED 6 Could not be 4 🗌 Homicide 28 tem R 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. FUNERAL (within 72 h TANT: If it HOSPITAL 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as steted. TO THE HOSPITA
TO THE FUNERA
DE filed within 7
IMPORTANT: I 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE soyee MD Dotober 27, 1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 WISCONSIN Ave, BeThesda, Md 20814 32. MEGISTRAR'S SIGNATURE 31 1995



burial-transit permit. Pages 1, 2, 3 should

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NDING PHYSICIAN: The law it: After this certificate has by r death with the State Dept.	is marked, or item 23 shows
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Item 28 is marked, or item 23 shows any injury, or other traumatic eveni, the medical examiner must be notified at once.

COMPLETED

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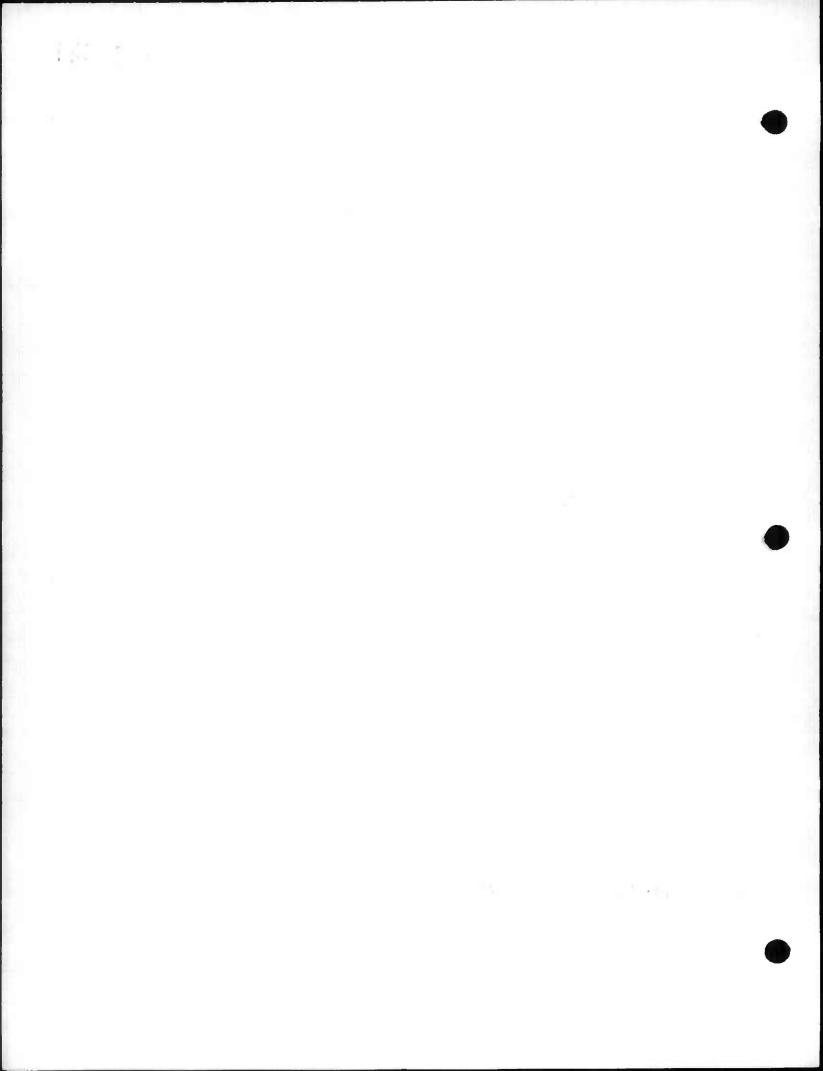
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IMPORTANT: II

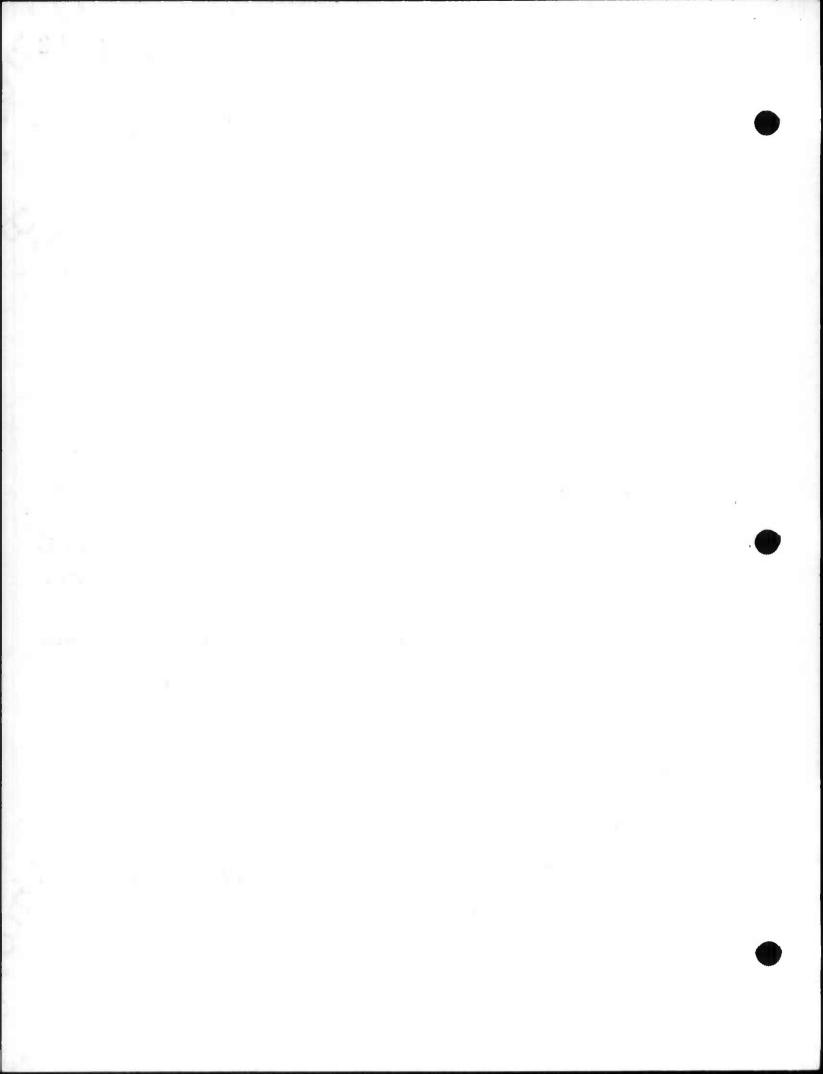
1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH VEAR Panagiota Sakellaris October 995 10:45A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign 217-42-8261 DAVE Feb 20 Year) 1901 1 M 2 F 94 YRS. Greece 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Randolph Hills Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Maryland Montgomery Silver Spring 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Whitehaven Road 20906 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 2 NO 1 Never Manied 2 Merried IF YES, GIVE WAR OR DATES В 3 X Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp. Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Seamstress 6TH. Grade 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harry Michalopoulos BE Sourlis Demetra 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Peter Sakellaris 16309 Whitehaven Road Silver Spring. Md. 20906 20s. METNOD OF OISPOSITION
1 X Burlel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Nema of DATE | 20c. LOCATION — City or Town, State Gate Of Heaven 10/31 Silver Spring, Md. 22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 11800 New Hampshire Ave. Silver Spring, Md. mac 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Pneumonia and sepsis week DUE TO (OR AS A CONSEQUENCE OF): Senile Inanition years CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE progressive dementia 1 TYES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 🖾 Nursing Nome 5 🗆 Residence 6 🗆 Other (Specify) I ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 26b. TIME O 28d, DESCRIBE HOW INJURY OCCURED 1 🔯 Natural BY

5 Pending Investigation 1 YES 2 NO 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Nomicida 29a, CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) C D08944 October 30,1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martin C. Shargel M.D. 3720 Farragut Ave. Kensington, Maryland 20895-2110 33. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) OCT 31 1995 lis Davelson Revolath



BALTIMORE, MARYLAND 21215-0020	iours after death. Page 6 may be retained by the hospital or attending physician.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed withing a figure of the continuation of the contin

	REGISTRAR		LAND / DEPA CERTI	FICATE O	F DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	H	She	+MAN		2. DATE OF DEATH	~ 0 c	YEAR 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	IF UNDER 24 HRS.	7 DATE OF BIRTH	0 (0	8. BIRTHPLACE (State or Foreign				
	218 - 01 - 6351	1⊠ M 2 □ F 83	(In yrs. last birthday YRS.	MONTHS DAYS		(Month, Day, Year)	912	Virginia	
	9a. FACILITY NAME (If not institution, give			9b. CITY TOW	N OR LOCATION OF DE			TY OF DEATH	
CTOR	Laurel Regional			Laurel				ce George	
REC	U 10e. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION								
5	Maryland Howa	rd	La	urel				LIMITS?	
7	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?	
FUNERAL	9074 Old Scaggsv	ille Road			20723		USA		
Ž	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13 WAS D		NC ORIGIN? (Specify Ye		14 BAOT A	
- 11	1 Never Married 2 X Married	FORCES? 1 X YES	2 NO	If yes,	specify Cuban, Maxica	n, Puerlo Rican, etc.)	or No-	 RACE — American Indian, Black, White, alc. 	
BY	3 Widowed 4 Divorced			1 🗆 Yı	ES 2 NO Specifi	r'		Specify:	
G	15. DECEDENT'S ED	World War		'S USUAL OCCUPA	7.01	Marine Control of the		White	
ETE	(Specify only highest grad	de completed)		f work done during i		18b. KIND OF BU	SINESS/INDU	STRY	
٦	Elementary/Secondary (0-12)	College (1-4 or 5+)					C **	3	
Ž	Grade 6		Locksm	ith		State o		yland	
COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Surname)		
w	Maynard Sherman				Mary Ma	iuck			
0 8	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Stree	t and Number or Rural I	Route Number, City or Tow	n, State, Zip C	Code)	
ř	Anna M. Sherman		9074	Old Sca	agsville	Road, Laur	cel, M	aryland 2072	
	20a. METHOD OF DISPOSITION	20'	b.PLACE AND DAT					ty or Town, State	
	1) Burlet 2 Cremetion 3 Rer	moval Irom State COI	metery, crematory or	other placel	ial Park				
	21. SIGNATURE DE PUNERAL SERVICE L		Padowitio		AND ADDRESS OF FA	10/28 Doz	.sey,	Maryrand	
	-6)11-110	6/1/		Donal	dson Fune	ral Home,	P.A.		
	how the	Marly						land 20707	
CERTIFICATION	disease or condition resulting in death) e. Unit culot to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF): CALSE (Disease or Injury that initiated events) Due to (OR AS A CONSEQUENCE OF):								
	resulting in death) LAST	d. Clara	1 055	410	we Lan	JUSEC	U	year	
15 17						, ~			
198	PART ii. Other significent conditio	ne contributing to deeth t	but not resulting	in the underlyi	ing cause given in	Part i Jan une au	ALIMOROV	AAL WEDS AUTODON FORD	
A	PART II. Other significent condition	one contributing to deeth t	but not resulting	in the underlyi	ing ceuse given in	Part i. 24s. WAS AN PERFOR		AVAILABLE PRIOR TO	
A	PART II. Other significent condition	ne contributing to deeth t	but not resulting	in the underlyi	ing ceuse given in	Part i. 24a. WAS AN PERFOR	MED?	AVAILABLE PRIOR TO	
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BALTIMORE, MARYLAND 21215-0020	the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physici
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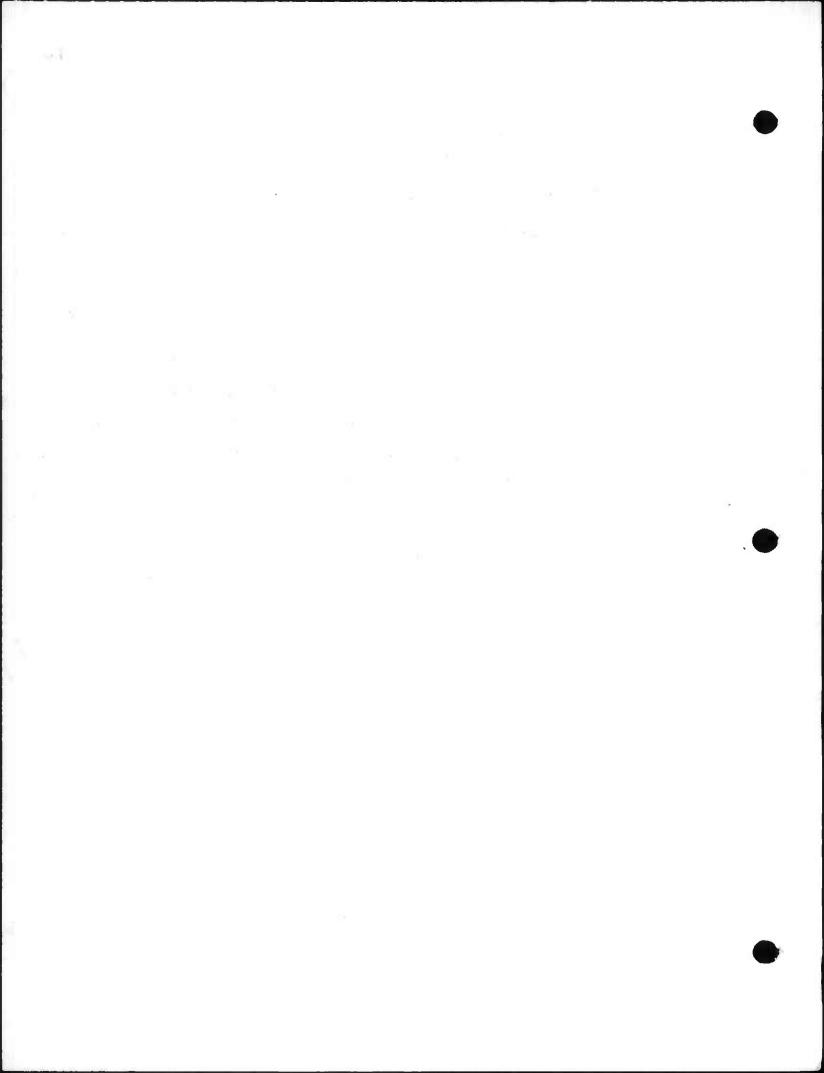
DIVISION OF VITAL RECORDS, P.O.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or remoyal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	TMENT O	F HEALTH	AND N	MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH OCT 29			3. TIME OF DEATH
)	Mary Bernade	tte Smith	te Smith						95 ^{SAR}	12:49 P M
-	4. SOCIAL SECURITY NUMBER	S. SEX 6. AGE (In y	EX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.							IPLACE (State or Foreign
	571-407057	□ M 2X F 87	M 2 F 87 YRS. MONTHS DAYS HOURS MIN.					7. DATE OF BIRTH (Month, Day, Year) Jan 24, 1908 S. BIRTHPLACE (St. Country) Michigan		
	9e. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TO	WN OR LOCATI	ON OF DE			TTY OF D	
DIRECTOR	Bon Secours Extende	ed Care Facil	ity	Ell	icott	City			owar	
Æ	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR L	OCATION		-			10d. INSIDE CITY
5	Maryland How	ward		Columb	ia			LIMITS? 1 YES 2 NO		
AL	10e. STREET AND NUMBER				101. ZIP CODI	Ε		WHAT COUNTRY?		
ER	6211 Woodleigh Driv	<i>r</i> e			2	21044 United Stat				Statos
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or N								- 14. RACE — American Indian		
BY F							1	Speci	t, White, atc.	
										White
I	15. DECEDENT'S EDUCAT (Specify only highest grade co.	MoN (mpleted)	a. DECEDENT'S (Give kind of v	work done durin	PATION g most of working	ng	18b. KIND OF BI	JSINESS/IND	USTRY	
, E	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT us							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	2	Teach	er				cation	1	
	and the second s						RE (First, Middle, Maide			
BE	Hugh Byrnes 190. INFORMANT'S NAME (Type/Print)		T	<u></u>			et Elizab			ty
2		_					oute Number, City or To			
	Mary Kathleen Brock					rive	Columbia			
	1 X Buriel 2 Cremation 3 X Remova 4 Donetion 5 Other (Specify)	of from State compler	ACEANDDATE OF OR OF OR OF OR OF OR	ther place)	N (Name of		1	OCATION —		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE ALL	Sours		E AND AODRES	SC OF FAC	#1-3 LOI	ng Bea	ach,	California
	> Shemi a.	0.00.		Har	ry H. V	Witz	ke Funeral			
	0			411	2 Old (Colum	mbia Pike	Ellic	ott	City 21043
	23. PART I. Enter the diseases, or con shock, or hasrt fallure. Lia	nplicationa that caused th it only ona cause on aach	a death. Do n Ilna.	ot entar tha	moda of dyi	ing, such	ss cardiac or resp	piratory arr	est,	Approximsta
	IMMEDIATE CAUSE (Final disease or condition		, ,	3 /						Onset and Daath
	reaulting in death) s. renal failue								2 wasts	
	disease or condition resulting in death) s. OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequantially list conditions, b.	DUE TO (OR AS A CO	NSECULENCE OF	alzein	24.2	aue	ase			75 YB
¥	if sny, lasding to immediate cause. Enter UNDERLYING		ocoocitor of	,.						i i
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF	7):						
H	reaulting in death) LAST									
	PART II Ohar slandiana and iist									
ÄL	PART II. Other significant conditions of	contributing to death but r	not reautting I	n the under	ying cause g	givan in P	Part I. 24s. WAS AF PERFO	-	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ğ							1 YES	2 NO		COMPLETION OF CAUSE OF DEATH?
Σ					. ,		_			1 TES 2 NO
AN	DID TOBACCO USE CONTRIE					ERTAIN				
PHYSICIAN: MEDIC		OSPITAL:	PLACE OF OEAT	H (Check only OTHER:	one)					
¥	1 VES 2 NO 1	☐ Inpatient 2 ☐ ER/Outpatien 28e. DATE OF INJURY		4 Nursing			Other (Specify)			
	1 🔀 Neturel 5 🗌 Pending	(Month, Day, Year)	28b. TIMI INJ	URY	INJURY AT WORK?		28d. DEŞCRIBE HOW	INJURY OCC	URED	
B	2 Accident Investigation 3 Suicide Could get be	28e. PLACE OF INJURY —	At home farm a		YES 2		205 LOCATION (Comme			
COMPLETED	4 Homicide S Could not be determined	building, atc. (Specify)		areat, ractory,	,,,,,,		28f. LOCATION (Street City or Town, State)	or Hural H	oute Number,
9	290. CERTIFIER									
₽ P	(Check only one)	N: To the best of my knowledg	e, desth occurre	d at the time,	date end plece,	end due to	o the cause(e) end me	nner se state	d.	0.000.000000000000000000000000000000000
8	Commence of the second	On the besis of examination en	d/or investigation	n, in my opini	n, death occur	ed at the ti	ime, date end place, e	nd due to the	ceuse(e)	end menner ea stated.
BE	296. SKINATURE AND TITLE OF CHEMPIER	. In 1/h			29c. LICE	NSE NUME	BER	29d. DATE	SIGNED	(Mpnth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	y muss	(TEX		1)2	.662			0130	145
	3460 Ellicott C	enter Drivo	(ITEM 27) (Type,	llicott	Cit	1. /	Many Cord	,	2104	3
	31. DATE FILEO (Month, Day, Yber) OCT 3 1 1995	82 REGISTRAR'S SIGNATURE	RE .) (10.0			
		4								



BAI	e after des
	Sire 2
13146,	executed within
O. BOX	certificate he
۵.	death
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TAL OR ATTENDING DAVCICIAN. The law requires that the death certificate be executed within
TALF	The faw
OF VI	PHYCICIAN.
VISION	ATTENDING
ā	N OB
	MTA

after death. Page 6 may be retained by the hospital or attending physician.	inficate has been sloned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be offered for use as the burial-transit permit. Pages 1, 2, 3 should be standard the standard burial compation or removal.	ical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within hurs after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the the fleet within 72 hours after death with the State Dent, of Health and Mental Hydiene prior to Burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND A	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	0	F DEAT	H		REG. NO.

	1 - FOR STATE REGISTRAR		STATE OF MAR			ENT OF H		MENTAL	HYGIENI REG. NO.			
	1. DECEDENT'S NAME (First	ED/	DONA	STUL	TZ			2. DATE MONTH		199	EAR .	TIME OF DEATH 7:15 P M
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 8. AGE (In yrs. last birthday) 1 F UNDER 1 YEAR IF UNDER 24 HRS. (Month, Day, Year) ON THE DAYS HOURS MIN. (Month, Day, Year) ON THE DAYS HOURS MIN. (Month, Day, Year)								MATO	CE (State or Foreign		
ב	2061 NO	RTH FER	~	>	7.	ANES	R LOCATION OF DE		21787	9c. COUNTY	CRUZ	
FUNERAL DIRECTOR	MD.	10b. COUNTY	024				WN 21	787	7		1[I. INSIDE CITY LIMITS? YES 2 NO
NEDAL	100. STREET AND NUMBER 206/NO 11. MARITAL STATUS	RTH I	FEESER	/50 W W O A STATE	-		2178	7		0	1.5.+	COUNTRY?
20	1 Never Married 2 3 Wildowed 4 Divi	Married	12. WAS DECEDENT EY FORCES? 1 IF YES, GIVE WAR	YES 2 NO	EO	If yes, sp	ENDENT OF HISPAN celfy Cuban, Maxica 2 10 Specify	n, Puerto F		or No 14	Black, Wi Specify:	American Indian, hita, atc.
LEIED		CEDENT'S EDUCA by highest grade co (0-12)	College (1-4 or 5+)	(Give	kind of work o	red.)	furing most of working					
COMPLE	17. FATHER'S NAME (First, A	Middle, Last)	0		cuck	DRIV	18. MOTHER'S NA	ME (First, A	fiddle, Maiden	Surname)		
IO BE									1787 NWN MD			
	20a. METHOD OF DISPOSIT 1 Burlal 2 Cremati 4 Donation 5 Othe	TION lon 3 - Remov		20b. PLACE Of	F DISPOSITIO	N (Name of cer	notory, crematory or	on	20c. LO	CATION - CH	_	
21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY GIWINIS MYERS FANDAGE HOME NESTA												
	23. PART I. Enter the c shock, or it IMMEDIATE CAUSE (Fi disease or condition resulting in deeth)	haart feilure. Li	COLO	on aach iina.	ARCI		de of dying, such				t,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d											
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Particle CONCEESTIVE HEART FAILURE						Part i.	PERFORMED?			RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED EXAMINER?		HOSPITAL:	2/Outpetlant 3 [HER:	ACE OF DEATH (Ch					
	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 Netural 5 Pending						URY AT	Residence 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED				
IEU BY	2 Accident investigation 3 Suicide 2 Could ask has 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LO							LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLEIED	anal		AN: To the best of my									nd menner as stated.
O BE C	296. SIGNATURE AND TITL	E OF CERTIFIER	Threein,	m·D.			29c. LICENSE NUI	MBER		29d. DATE S	SIGNED (MC	onth, Day, Year)
	30. NAME AND ADDRESS O	R. LI	NTHICOI	n, m.D.			UGS DRIV	IE, T	ANEYT	row N	mD	21787
	31. DATE FILED (Month, Day	(100E	32. REGISTRAR'S	SIGNATURE								

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPIAL OF AT INDIGIANT: The law requires that the death centhicate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNESAL DIRECTION After this center has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
S SE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.
Bernard Carter Sellman	2. DATE OF DEATH NOVEME

	1 - FOR STATE REGISTRAR	STATE OF MARYL		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S HAME (First, Migdio, Lost) Belin Gud	CBernard		lman	2. DATE OF DEATH NOVEM DAY	IBER 3. TIME OF DEATH			
	214 12 7855	10M 2 D F	77 YRS. MONTH		7. DATE OF BIRTHOCTOBE (Month, Day, Year)	Sountry) MARYLAND			
TOR	Pen Cojew Must in Pension of December 1			Lun Lon		OUNTY OF DEATH			
DIRECTOR		nce George'		cokeek		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 [X] NO			
FUNERAL	2000 Accokeek	Rd. West		20607	10g. (U.S.A.			
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 300	IS. WAS DECENDENT OF HISP/ If yea, specify Cuban, Maxis 1 YES 2 NO Spec					
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5 +)	life. Do NOT use retire	ne during most of working d.)	16b. KIND OF BUSINESS/				
OM	17. FATHER'S NAME (First, Middle, Last)		Truck Dr		Farm Suppl	*			
BE C	Bernard Carte	c Sellman		Carol		ellman			
2	10a. INFORMANT'S NAME (Type/Print) Anna Sellman				I Route Number, City or Town, State,				
	20a. METHOD OF DISPOSITION	20h		x 83 Accok	DATE 20c LOCATION	City or Town State			
	1 Durial 2 Commention 3 Ren 4 Donation 5 Other (Specify)	noval from State	PLACEAND DATE OF DISE	n Crem.	11/4/95 Alex	kandria, VA			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE CERLE	A	REHART-ECH	OLS FUNERAL LaPlata.MI	HOME, INC.			
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that ceused List only one ceuse on ea	the death. Do not en	ter the mode of dying, au	ch as cardiec or reepiratory	arrest, Approximate interval Between			
	iMMEDIATE CAUSE (Final disease or condition reaulting in death)	CEREB	BROVAS	CUCAR	DISEASE	Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CORDINARY ARGERY DISEASE								
PHYSICIAN: MEDICAL C	PART II. Other aignificant conditions contributing to death-but not resulting in the underlying ceuse given in Part I. URINARY TRACT IMPECTION 1 YES 2 KNO CELLUSTIS.								
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН	26. PLACE OF DEATH (C	heck only one)				
	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Dinpatient 2 ER/Outp. 28e. DATE OF INJURY (Month, Day, Year)		6 ☐ Other (Specify) 26d. DESCRIBE HOW INJURY (OCCURED				
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, street, i	1 VES 2 NO	261. LOCATION (Street and Num City or Town, State)	ber or Rural Route Number,			
COMPLETED					e to the cause(e) end manner ee o	stated. the cause(e) and manner se stated.			
TO BE C	296. SIGNATURE AND TITLE OF GERNIFIE	or show	MI	29c, LICENSE NU	7744 Þ	DATE SIGNED (Month, Day, Year)			
	39 ATME AND ADDRESS OF PERSON WITH A SAME A	NI MD	9131 Pis	SCATAW	AY PD	CLINTONMO			
	NOV 0 6 199	5 July Must	Lion Randall						

BALTIMORE, MARYLAND 21215-0020 hours after death. DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should permit. Page 6 may be retained by the hospital or attending physician. all director, page 5 should be detached for use as the burial-transit once. notified at pe must the funeral director, examiner medical completely filled in by 00 other traumatic event, the burial, physician and prior to signed by the attending Health and Mental Hygiel has been e Dept. of h 23 Item r this certificate his 10 marked, DIRECTOR: After the hours after death v 28 FUNERAL within 72 h MPORTANT: IL F fled v

DIRECTOR

FUNERAL

87

8

ᄪ

COMPL

2

CERTIFICATION

MEDICAL

PHYSICIAN:

87

COMPLETED

BE

2

296. SIGNATURE AND TITLE OF CENTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

101

1 - FOR STATE REGISTIRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR SPEARMAN. SR. JAMES 1995 October 7:30 A.P. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS 579-36-8268 76 1 M 2 F June 10, 1919 Greenwood, 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1321 Sycamore Avenue Annapolis Anne Arundel RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Annapolis 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1321 Sycamore Avenue 21403 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-II yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 Married 1 YES 2XXNO Specify. 3 Widowed 4 Divorced Black 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5+) U. S. Postal Service Retired Postal Employee 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Simeon L. Spearman Florence L. Calhoun 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Spearman, Jr. 1321 Sycamore Avenue, Annapolis, Maryland 21403 20a. METHOD OF DISPOSITION

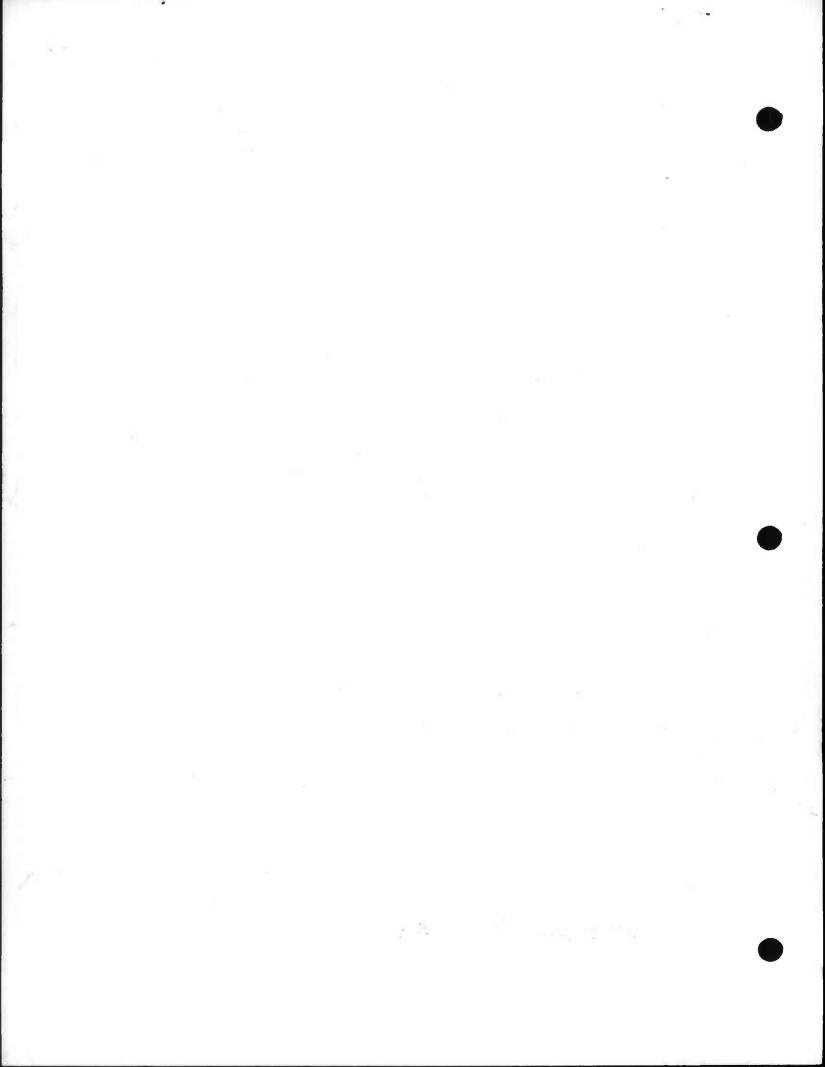
1 X Burlai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Glenwood Cemetery 10/26/95 Washington, D.C. 11. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEWART FUNERAL HOME 4001 Benning Road, N.E., Washington, D. C. 23. Port I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heert fellure. List only one cause on each line Interval Between **IMMEDIATE CAUSE (Finel Onaet and Death** disease or condition searce resulting in death) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO upertonsion 1 TES 20 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO DE UNCERTAIN [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only or HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED Natural 2 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 YES 2 NO investigation Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

0293

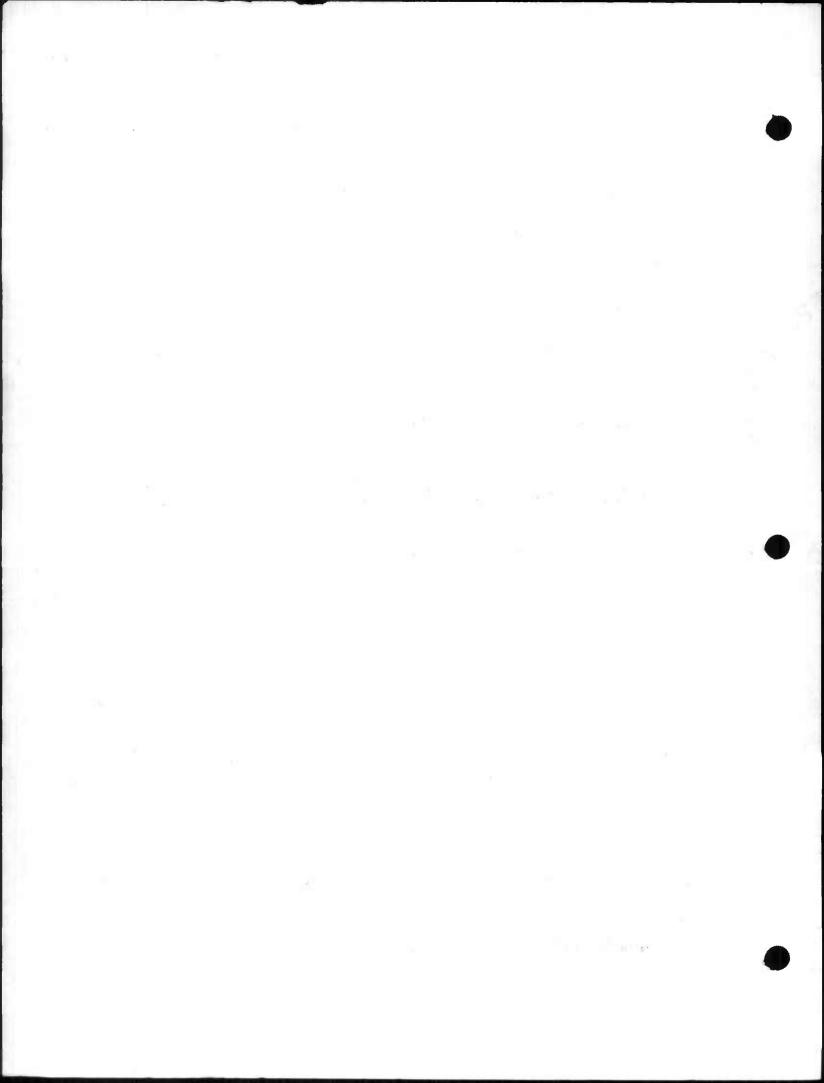
auton MD 21114

29d. DATE SIGNED (Month, Ded. Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALLIMORE, MARTLAND 21213-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	4 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Debt, of Health and Mental Hyplene prior to burial, cremation, or removal.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin State Debt, of Health and Mental Hyplene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	e medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF	MARYLAND C		RTMENT				MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle,	Lest)								OF DEATH	w	YEAR	3. TIME OF DEATH
	STEWART	H	3		S	HOF	REY		NOVE				2215 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. Is	st birthday)	IF UNDER 1		IF UNDER		7 DATE C	E BIOTH		A BIRTHE	LACE (State or Foreign
1	043-20-2920	11 M 2 - F	71	YRS.	MONTHS	DAYE	HOURE	MIN.	July	3, 19	924	Country	ine
	90. FACILITY NAME (If not institution,	give street and number)			9b. CITY,	TOWN C	R LOCATI	ON OF D				NTY OF DE	ATH
2323 URBANA PIKE URBANA RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										FRE	EDER	CK	
											10d. INSIDE CITY LIMITS?		
=	Maryland M	ontgomery		C	larks	burg	g					1	1 YES 2 NO
4	10e. STREET AND NUMBER					101	. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?
HH	24625 Clark	sburg Road					2	2087	1			U.S	.A.
11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED 1 Never Merried 2 Merried 1 Never Merried 3 Merried 1 Never Merried 3 Never Merried 1 Never Merried 4 Never Merried 1 Never Merried 5 Never Merried 1 Never Merried 5 Never Merried 1 Never Merried 6 Never Merried 1 Never Merried 7 Never Merried 1 Never Merried 8 Never Merried 1 Never Merried 9 Never Merried 9 Never Merried 1 Never Merried 9 Never Mer										or No-	14. RACE	— American Indian,	
								White, etc.					
6 3 Widowed 4 Divorced World War II							wnite						
15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY													
	Elementary/Secondary (0-12)	College (1-4 or							butte	on Eng	. Arı	ny Co	rp.
를	10			Sys	stems	Ope	rato	r	Ducie	n En	ginee	ers	
COMPLET	17. FATHER'S NAME (First, Middle, Las	e)		-			18. MOT	HER'S NA	AME (First, M	liddle, Meiden	Surname)		
BE (Unknown							Ina	Shor	ev.			
10	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILIN	G ADDRESS	(Street a				er, City or Tow	n, State, Zi	ip Code)	
F	Susan Johnson			2462.	5 Cla	rksl	ourg	Roa	d. C1	arkeh	uro	Mary	land 20871
	20e. METHOD OF DISPOSITION 1 Burlel 2 A Cremetion 3	Dimensi Anna State	20b. PLACE	ANDDATE	OF DISPOSE				DATE	20c. LO	CATION -	City or Tov	vn, State
1 1	4 Donation 5 Other (Specify)		cemetery, co	gome	other plece) rv Cre	emat	ori	1m	11/0	4 Ros	theco	la M	aryland
	21. SIGNATURE OF FUNERAL SERVI	CE LICENSEE	1		22. N	IAME A	ND ADDRE	SS OF F	ACILITY				-
	►(1)V.	Pan.	1	L	0]	lin	L. M	lo1es	swort]	h,P.A.	, Fu	inera	l Home
	Cum o	. 10 00	swar		26	5401	Rid	ge]	Road.	Damas	cus,	Mary	land 20872
	23. PART I. Enter the diseases ahock, or heart fall	ure. List only one c			not enter	tne mo	de or dy	ing, aud	on aa card	lec or reap	iratory ar	rrest,	Approximete Interval Between
1 1	IMMEDIATE CAUSE (Finel		0 0 0 1										Onset and Death
	disease or condition resulting in deeth)	. HEA	1) 4 04		IN	JUK	162						
		DUE '	Ó (OR AS A CONSI	EOUENCE (OF):								
Z	Sequentially list conditions,	b											
Ĕ	If any, leading to immediate	DUE	O (OR AS A CONSI	EOUENCE (OF):								
2	CAUSE (Disease or Injury	C			_								
	thet initiated events reaulting in death) LAST	DUE	O (OR AS A CONSI	EOUENCE (OF):								
CERTIFICATION	Touching III de attil) Error	d											
								WERE AUTOPSY FINDINGS					
PERFORMED? 1 Yes 2 No OF DEATH? 1 Yes 2 No							AVAILABLE PRIOR TO COMPLETION OF CAUSE						
							OF DEATH?						
							1 YES 2 NO						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
ō	EXAMINER?	HOSPITAL:			OTHER	-							
ΥS	1 XYES 2 NO		ER/Outpetient					esidence	8 XOther			SCENE	E
표	1 Natural 5 Pending	28e. DATE (Month	Day, Year)	IN.	IJURY		PRK?		DEILA	CRIBE HOW	DALL!		AUTO ,
B	2 Accident Investiga	itlon 12	45	1210		t 🗌	7	KNO				COL	USION
8	3 Suicide 8 Could n	or De buildin	OF INJURY — At I		, street, tecto	ory, offic	a			ATION (Street or Town, State		er or Rural A	oute Number, M
	V Homotov		3	Truc					2323	URBAI	JA FA	SKMAY	, FREDRICK
COMPLET		PHYSICIAN: To the beat	ot my knowledge, o	death occur	rred at the til	me, date	end place	e, end du	e to the ceu	se(s) end me	nner as at	sted.	
o o	one) 2 MEDICAL EX	AMINER: On the pasis o	xamination end/o	r Investigat	ion, in my o	pinion, o	leath occu	red at the	e time, date	end place, e	nd due to t	the couse(s)	end menner es stated.
	206. SIGNATURE AND TITCE OF CER	TIFIER /	1		-		29c. LIC	ENSE NU	IMBER		29d. DA	TE SIGNED	(Month, Day, Year)
) BE	MULT	YXU -	4				0.	C.M	.E.		Rio	VEMP	ER 3,1995
유	30. NAME AND ADDRESS OF PERSO	WHO COMPLETED C	LUSE OF DEATH (IT	EM 27) (Typ	e, Print)		_ ~ •	1			1 140	۵ تایات	LIN 3, 1333
	MAKIO F. GI	ONK JR	M121	Penn	Str	eet	. В	alt	imor	e, Ma	aryl	and	21201
	31. DATE FILED (Month, Day, Year) NOV 06 1995 32. REGISTRAR'S SIGNATURE Silvin Davidson Revealed												



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H	HEALTH AND N	MENTAL HYGIEN	E		
	DECEDENT'S NAME (First, Middle, Last)	Anthony	В. 8	Smith		2. DATE OF OEATH DA NOV. 2, 19	YEAR	3. TIME OF DEATH 10:52 A M	
	4. SOCIAL SECURITY NUMBER 189-01-8652	1 K M 2 □ F 9	in yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 14, 190	Cot	THPLACE (State or Foreign ontry)	
TOR	90. FACILITY NAME (If not institution, give Potomac Valle RESIDENCE OF DECEDENT		е		OR LOCATION OF DE	ATH	Monte	omery	
DIRECTOR	10e. STATE 10b. COUNT	tgomery		Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	9816 Moyer Road			101	20872		10g. CITIZEN OF	WHAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPAN ecity Cuben, Mexicar 2 1 NO Specify	IC ORIGIN? (Specify Yea 1, Puerto Rican, etc.)	or No — 14. RA Bit	CE — American Indian, lck, White, atc. acity: White	
COMPLETED	15. DECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12)	Cation o completed) College (1-4 or 5+)	(Give kind of a life. Do NOT us	usual occupation work done during more retired.)	est of working	166. KIND OF BUSINESS/INDUSTRY Library			
111 8	17. FATHER'S NAME (First, Middle, Last) Joseph Smith				Ellen				
TO TO	Shirley M. Richar		9816	Moyer Ro	oad, Dama	oute Number City or Town	land	20872	
examiner must	1 N Buriel 2 Cremetion 3 Removed from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery 11/6 Wilkes-Barre, Penna. 21. SIGNATURE DF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 01in L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 2087								
ry, or other traumatic event, the medical	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Approximate interval Between Onset and Death DEATO (OR AS A CONSEQUENCE OF): B. ALCUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 DENO 24b. WERE AUTOPSY FINO COMPLETION OF CAU OF GEATH? 1 YES 2 DENO 1 YES 2 DENO 1 YES 2 DENO								
SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WOLCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
Is marked, o	1 YES 2 NO 1 Inpettent 2 ER/Outpettent 3 DOA OTHER: 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be Published as Could not be Published as Could not be Published as Could not be Provided in the Published								
COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowle	edge, death occurre	n, in my opinion, d	and place, and due t	to the cause(s) and ment	ner se stated.	(s) and manner as stated.	
TO BE CON	2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29c. LICENSE NUMBER D 01/20 Nov. 2, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter E. Goozh, M. D. 2309 Shorefield Rd., Wheaton, Md. 20902								
	31. DATE FILED (MOORS DO. 19) 3-19		Type Wilson-Rand	Tri-	.u iu., W	nea wn, Md	. 20902		

. . es 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BARBARA FLORA SMITH OCTOBER 31 1995 7:40 A. M 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 1 M 2 F 231-03-6208 74 Dec. YRS. 20, Virginia 1920 9a. FACILITY NAME (If not inetitution, give 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 19013 Jonesville Terrace Poolesville Montgomery RESIDENCE OF DECEDENT 10a, STATE 10b. COUNT 10c, CITY, TOWN OR LOCATION 104. INSIDE CITY Maryland Montgomery Poolesville 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 19013 Jonesville Terrace 20837 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Pu 1 Never Merried 2 Merried Specify: BY 3 🕅 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRO College (1-4 or 5+) 12 self homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) BE Robert Wesley Cline Mary Maggie Stevens 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19013 Jonesville Terrace, Poolesville, MD Randy R. Smith 20837 20e, METNOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremation 3 ☐ Rer 1 10/02 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Resthaven Memorial Gardens 1995 Frederick, Maryland Other (Specify) IL SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITYS tauffer Funeral Home man 1621 Opossumtown Pike, Frederick, MD 21702 the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23. PART I. Enter the diseas **Approximata** shod Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition Concer with Disconno Margapages Pul 95 TERMINAL resulting in death) DUE TO (OR AS A CONSEQUENCE OF) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEL ZUNG DUMPK 2 CLUBTOR NUTANTASSE 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO COPO MININ (Fix CHOMIL 1 TYES 2 NO DID TOBACCO USE CONTRIBUTÉ TO CAUSE OF DEATH YES NO UNCERTAIN D 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA me 5 Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 44 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Lucus VWY/ NOU 01 D00095 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HACTOR ASHIKLOW, MD Palkan 17600 WED WILLARD BUND 32. REGISTRAR'S SIGNATURE Parlall 31. DATE FILED (Month, Day, Year) 01

BALTIMORE, MARYLAND 21215-0020	nours after death, Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withman, hours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the fune be fled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH
	JAMES ALAN SKIFF									October 30, 1995			3:40 m	
			5. SEX	6. AGE (In yrs. lest birtho				R IF UNDER 24 HRS.		7. DATE OF BIRTH		6. BIRTHPLACE (State or Foreign Country)		
	071-26-8237 1X M 2 □ F 59			YRS.	MONTHS	DAYS	HOURS	MIN.	Apri	Day, Year) 1 24,	1936	Ne	w York	
~	9a. FACILITY NAME (If not institution, give street end number)						,	OR LOCATION		EATH		9c. COU	INTY OF DEATH	
D	Citizens Nursing Home					F	rede	erick				F	rede	rick
DIRECTOR	10e. STATE 10b. COUNTY				10c. CIT	c. CITY, TOWN OR LOCATION							10d. INSIDE CITY	
<u>=</u>	Maryland Frederick					Fred	lerio	ck						LIMITS?
A	10e. STREET AND NUMBER	1				10f. ZIP CODE					10g. CITIZEN OF WN			WNAT COUNTRY?
FUNERAL	271 Pin Oak	Lane				21701					United S			States
5	11. MARITAL STATUS	Married	12. WAS DECEDEN FORCES? 1	TEVER IN U.S.	ARMED NO	13.	WAS DEC	ENDENT C	F HISPAN	NIC ORIGIN	(Specify Yellow)	s or No—	14. RACI	E — American Indian, k, White, etc.
BY	3 Widowed 4 Divo		1954-	AAR OR DATES			1 YES	XX NO	Specify	y:			Spec	
	15. DEC	EDENT'S EDU	CATION	16e.	DECEDENT'S	USUAL O	CCUPATIO	ON		16b.	KIND OF BU	SINESS/INC	DUSTRY	White
COMPLETED	Elementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5		(Give kind of the Do NOT us	work done se retired.)	during mo	st of worldn	g	-				
MP			4		Sale	S					Tire	e Com	pany	
8	17. FATHER'S NAME (First, M										iddle, Meiden	Sumeme)		
8	Alan W. Sk									Rekem				
임	Elizabeth		t t		19b. MAILING									
	20e. METHOD OF DISPOSIT 1 Burlel 2 2 Cremetic			20h PLAC	Z / I				Fr		ick, A			
	1 ☐ Buriel 2 🖄 Cremetic 4 ☐ Donation 5 ☐ Other	(Specify)	oval from State	cametery.	crematory or o	ther placel								
	4 Donation 5 Other (Specify) Hagerstown Crematory 1/1/3/95 Hagerstown Stauffer Funeral Service (ICENSEE) 21. SIGNATURE OF FUNERAL SERVICE (ICENSEE) 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Stauffer F						oral	al Homes, P A						
	1621 Opossumtown Pike Frederick, MD							MD 21702						
	23 PART I Enter the di	iseases, or c	complications the	it ceused the	deeth. Do									Approximete
	shock, or h	esit tellure.	List only one ceu	use on esch II	ine.						-		2001	Interval Between Onset and Death
1	disease or condition		MULT DUE TO	IRE	SCL	ERC	22							2100
	rooming in addition		DUE TO	(OR AS A CONS	SEQUENCE O	F):								1-7/3
N	Sequentially list conditi	Sequentially list conditions b.												
AT	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING													
밀	CAUSE (Diseese or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):									-				
CERTIFICATION	resulting in death) LAST													
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
MEDICAL		teading	sulting in the underlying ceuse given in Part					PERFORMED?			WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE			
ED											T YES 2 LYNO		OF DEATH?	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							1 TES 2 NO						
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)													
SIC	EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)													
PHYSICIAN:	27. MANNER OF DEATH 28e. DATE OF INJURY					28b. TIME OF INJURY AT 28d. DESCRIBE HOW INJURY OCCURED WORK?						CURED		
₽	1 Natural 5 Pending 2 Accident Investigation					M 1 YES 2 NO								
	3 Sulcide 8 Could not be 4 Homicide determined					street, tact	lory, office	•		28t. LOCA City o	TION (Street of Yown, State)	t and Number or Rural Route Number, e)		
COMPLETED	4. 44					_								
MPI	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) and manner as stated.													
	29b. SIGNATURE AND TITLE			AWTHINERION BING/C	ur investigatio	en, in my o	pinion, d				ind place, an			
8		OF CERTIFIER	MAD					29c. LICE					SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF		O COMPLETED CAU	SE OF DEATH (1)	TEM 27) (Type	Print)			470	011	_		. 1 , 1	10
				·			Λ	***				1 1	0.1	
Dr. Neil V. Waravdekar, M.D. 1475 Taney Ave. Frederick, Maryland 21702							702 I							
	31. DATE FILED (Worth Day	Want	22 DECISTRA	DIO CICNIATURE		aney	Ave	. F:	rede	rick,	Mary	Tand	21	702
		Want	22 DECISTRA			aney	Ave	. F:	rede	rick,	Mary	Tand	21	702

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		ge 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should
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ALTIMORE, MARYLAND 21215-0020	tth. Page 6 may be retained by the hospital or attending physician	funeral director, page 5
	atth	E .
-	9	4

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMF	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
i examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detacherval.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
er death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hosp
BALTIMORE, MARYLAND	DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF MARYLAI		TMENT OF		MENTAL HYGIEN	_				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	Meridith Russe	ll Shum	aker			MONTH DAY		5 7.50 A M			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 15 UNDER 1 YEAR 15 UNDER 24 MRS. 7. DATE OF BIRTH (Month, Day, Year) 17 UNDER 1 YEAR 15 UNDER 1 YEAR (Month, Day, Year) 18 UNDER 1 YEAR 15 UNDER 1 YEAR (Month, Day, Year) 19 UNDER 1 YEAR 15							BIRTHPLACE (State or Foreign Country)			
	213-16-01/6 1 XM 2 LF /5 YRS. Nov. 29, 1919 V										
œ		et and number)		9b. CITY, TOWN	OR LOCATION OF	DEATH	9c. COUNTY	OF DEATH			
5	The Pines			E	aston		Tal	bot			
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.										
	Haryrana -	n Anne's		Steven	sville			LIMITS? 1 ☐ YES ½ ☑ NO			
FUNERAL	304 Dorchester	D		,	of. ZIP CODE	OF WHAT COUNTRY?					
NE		KOAQ 12. WAS DECEDENT EVER IN U	0.40450	40 1110 00	21666 U.S.A.						
	1 Never Married 2 Married	FORCES? 1 TES	2 NO	If yes, s	pecify Cuban, Mexic	NIC ORIGIN? (Specify Yes	s or No- 14.	. RACE — American Indian, Black, Whits, stc.			
84	3 Widowed 4 Divorced	WW II	-5	10.16	S 2 🔀 NO Spec	ny:		Specify: White			
COMPLETED	15. DECEDENT'S EDUCA' (Specify only highest grade co		8a. DECEDENT'S (Give kind of w	vork done during n	ION lost of working	16b. KIND OF BU					
J.		College (1-4 or 5+)	Centr		ice Rep	C &	P Tel	ephone			
MC	1 2 17. FATHER'S NAME (First, Middle, Last)	2	CCITCI	a1 011		AME (First, Middle, Meiden					
Ö	Harry W. Shumak	er			The state of the s	e Russell	Surname)	E TEN			
38 C	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tow	n, State, Zip Co	de)			
5	Anne S. Wohlfor	d	216	Washin	gton St	.N.E., L	eesbu	rg, Va. 22075			
	20s. METHOD OF DISPOSITION **EXBuriel 2 [] Cremation 3 [] Remove		LACE AND DATE O		leme of	OATE 20c. LO	CATION — City	or Town, State			
	4 Donstion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	На	arper	Cemete	ry oct.	25, 1995 _H	arper	s Ferry, W.V			
	21.000	11/1/	7		ND ADDRESS OF FA	oein Fune	ral H	omes, P.A.			
	Here 77	regente	c,	106	Shamroo	k Rd. C	heste	r. Md. 21619			
	23. PART I. Enter the diseases, or cor shock, or heart failure. Lis	npil ec tions that caused that only one cause on sac	ha death. Do n h iine.	ot entar tha m	ode of dying, au	ch as cardiec or reap	ratory arrest	. Approximata interval Between			
	iMMEDIATE CAUSE (Final disease or condition	Couche	1 ada	W14.				Onset and Death			
	TPI/PI/PI EUEITO										
2		Cevebra	e met	astases	s. Carc	momeston	5				
E	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): Levebral malastasts, Cavernometons DUE TO (OR AS A CONSEQUENCE OF): Long On - Small cell cavernome of lung Due TO (OR AS A CONSEQUENCE OF):										
2	CAUSE (Disease or Injury C. Non-Small Cell Carcinome of lung										
CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST										
8	d										
¥	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE										
ğ											
M	1 TES 2 NO										
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
SIC		IOSPITAL:		QTHER:		a Other (Specify)					
Ή	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. IN	JURY AT	ED					
BY F	Natural 5 Pending 2 Accident Investigation	(Works, Day, reary	INJ		YES 2 NO	□ NO					
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — building, stc. (Specify)	Al home, farm, a	treet, fectory, offi	ce	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED											
MPL		N: To the best of my knowled									
00		On the basis of exemination a	nd/or investigation	n, In my opinion,	death occured at the	time, data and place, an	d due to the ce	euse(s) and manner as stated.			
8	296. SIGNATURE AND TITLE OF CERTIFIER	Sh Dine	1 Les		29c. LICENSE NU	MBER 5933		GNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH	(ITEM 27) /7/04	Print)	VC.	ファンノ	/(0.23.95			
	Michael D. Cro				d Ave.	, Easton	. Md.	21601			
	31. DATE FILEO (Month, Day, Year) 007 25 1995					, Labcon	,				
	001 25 1995	32. REGISTRAN'S SIGNATU	"Trustant								

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SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Fage 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages have within 72 hours after death with the State Dent of Health and Mental Houries not in hurial cremation as minimal and managed to be supported for use as the buriat-transit permit. Pages	MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once
AN: The	State D	r Item
HYSIC!	his cert	ked o
IDING P	After t	s mar
ATTEN	ECTOR	n 28 i
AL OR	AL DIR	If item
HOSPIT,	UNER!	ANT
TO THE	TO THE !	IMPORT

DIRECTOR

FUNERAL

BY

COMPLETED

BE

0

CERTIFICATION

MEDICAL

PHYSICIAN:

ВУ

COMPLETED

BE

2

30. WAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 John Menno Strite October 6:30 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign DAYS HOURS 216-14-5806 1 X M 2 1 May 19 Maryland 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Mennonite Fellowship Home Hagerstown Washington 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Clear Spring 1 TYES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 14254 National Pike 21722 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MADITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Il yes, specify Cube

1 YES 2 NO Specify Specify: 3 Widowed 4 Divorced White 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Farm Market 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Daniel M. Strite Annie G. Horst 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Strite 12201 Ryeland Lane Hagerstown, Md. 20e. METHOD OF DISPOSITION

A Burlel 2 Cemellon 3 Removal from State
4 Donation 5 Cemellon 1 cometery, cremetory or other place) 11/1/195 tougset Mennonite Cemetery 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 21. SIGNATURE OF FUNERAL SERBICE LICEN 12525 Bradbury Avenue Davis Funeral Home Smithsburg, Md. 21783 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition T unity DUBING FUNDATION DUE, TO (OR AS A CONSEQUENCE OF): reaulting in death) rectensin Sequentially list conditions, DUE TO OF AS A CONSEQUENCE OF: If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? rulmonery Researce 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident Investigation 28s. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be 4 🗌 Homicide 29e CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. als of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CHITIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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SMITHSBURG

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REED M.D.

0-31-95

JOHN

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the control of the cont	aw requires that the death certificate be executed with every after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should removal.
IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	edical examiner must be notified at once.

95 34553 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First Middle Last 2. DATE OF DEATH 3. TIME OF DEATH Mae Haze1 SEIBERT YEAR October 304 95 4. SOCIAL SECURITY NUMBER 5. SFY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 220-18-3254 Feb. 3, 1 M 2 X F 82 1913 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Washington County Hospital DIRECTOR Hagerstown Washington RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Washington Hagerstown 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1158 Luther Drive 21740 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 TES 2 NO Specify: BY Specify: white 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) aircraft mfg. assembler 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) Harry M. Jones Lillian May Smith BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Theresa L. Phillips 1240 Pope Ave., Hagerstown, Maryland 21740 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata 1 🖾 Buriel 2 🗆 Cremetion 3 🗆 Rem Boonsboro Cemetery 4 Donation 8 Other (Specify) 11-1-95 Boonsboro, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, MD 01 SCO 21740 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition resulting in death) MASSIVE INTRACEREBRAL HEMPROSE 36 IMS DUE TO (OR AS A CONSEQUENCE OF) HYPERTENSION NO Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate CERTIFICAT ceuse. Enter UNDERLYING CAUSE (Disessa or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? PERFORMED? ATRIAL FIBRILLATION 1 - YES 2 1 NO 1 - YES 2 1 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 TES 2 NO patient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28e. DATE OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY NIA NA Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, strest, tectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 8 Could not be 4 Homicide determined COMPLET 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(e) end menner as stated. (Check only one)

2 MEDICAL EXAMINER: On the besie of examination and/or investigation, in my opinion, death occured at the time, data and place, end due to the cause(e) end menner ee stated.

21740

29c. LICENSE NUMBER

28 0-40151 JEFFREY ZONEZ

29d. DATE SIGNED (Month, Day, Year)

HOSERSTOUP

WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

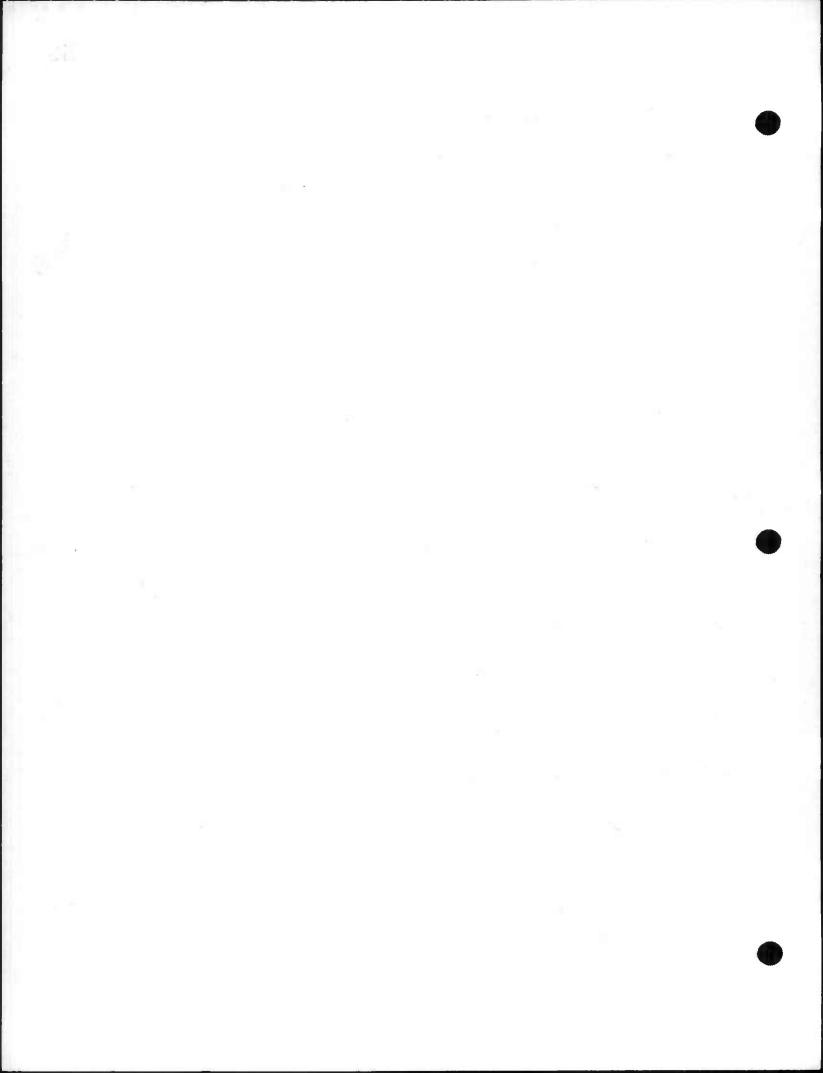
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30 NAME AND ADDRESS OF

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	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)		CEF	RTIFIC	CATE OF	DEATH	REG. N		I a	. TIME OF DEATN
	Ethel 1	Marie STO	TTLEMEYE	:R			MONTH	DAY	YEAR	
	4. SOCIAL SECURITY NUMBER						7. DATE OF BIRTH A BIRT			ACE (State or Foreign
	215-20-7298	1 - M 2 - F	71	YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year)	022	Country)	
	9s. FACILITY NAME (if not institution, give	street and number)	71	_	9h. CITY, TOWN	OR LOCATION OF D	Dec. 15,1		Mary.	
DIRECTOR	Washington Count		1			gerstown	eath 9c. county of death Washington			
<u> </u>	PESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	TY		10e CITY	TOWN OR LOCA	TION				
		shington			gersto					LIMITS?
FUNERAL	10m. STREET AND NUMBER HO1	y Place			10	H. ZIP CODE		10g. CITI	ZEN OF WHA	AT COUNTRY?
띮	268 South Potoma	ac Street				21740		Ţ	J.S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARME	D	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify	be or No —	14. RACE -	American Indian,
ВУ Б	1 Never Married 2 Married 3 4 Widowed 4 Divorced	IF YES, GIVE WAS			1 TYE	pecify Cuban, Maxico S 2 To NO Specific	n, Puerto Rican, etc.) y:		Specify:	white, etc.
ED	15. DECEDENT'S EDU	UCATION	18e, DECE	DENT'S U	SUAL OCCUPAT	ION	16b. KIND OF E	I ISINESS/IND	HETEV	
E .	(Specify only highest grad	completed) College (1-4 or 5+)	(Give	kind of wo	rk done during m retired.)	ost of working	ios. Killo or E	O SHILL SO / IND	OSINI	
	0-7	0		high	lighte		fur	niture	00	
COMPL	17. FATNER'S NAME (First, Middle, Last)				Q		ME (First, Middle, Malde			
В	Thurmond	A. Twigg				2000	Charlotte		hrout	
00	19a. INFORMANT'S NAME (Type/Print)		19b. N	AAILING A	DDRESS (Street		Route Number, City or To			-
5	Mr. Daniel Stottl	emeyer					et, Willi			21705
	20a, METNOD OF DISPOSITION		20b. PLACE AND	DATEOF	DISPOSITION /A	lame of	DATE 20c I	OCATION -	ity or Town	State
	1 🌣 Buriel 2 □ Cremetion 3 □ Ren 4 □ Donation 8 □ Other (Specify)	novel from State	Greenla	tory or other	vemoria	1 Park	10-24-95W	illiam	enort	MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	*	-4	22. NAME A	ND ADDRESS OF FA	CILTY Minnic	h Fune	rol E	Jomo
- 8	1 SCAN	tmy	1	. 1	415 E.	Wilson	Blvd., Ha	gereta	tran M	forwland
- 1	22 PADT I Enter the diseases of	/////	inne	70			zivar, na	501500	7	1740
ij	23. PART I. Enter the diseases, or ahock, or heart failure.	List only one ceuse	ceused the deatr on each line.	n. Do no	t enter the m	ode of dying, auc	h aa cardiac or ree	piratory arm	eat,	Approximata intervai Between
11	IMMEDIATE CAUSE (Finel disease or condition								Onset and Death	
	reaulting in death)	E CER	EBR	10 V/151	CULAR O	CCIDEN	IDENT			
	DUE TO (OR AS A CONSEQUENCE OF):									
O	Sequentially ilst conditions,	b. 5/2/20	1701	UEK.					34BARE	
F										
윤	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSCOUENCE OF):									
CERTIFICATION	resulting in deeth) LAST		χ							
S	d									
AL	PART II. Other algnificent condition	ns contributing to de	eeth but not ree	ulting in	the underlyin	ig ceuse given in		N AUTOPSY		RE AUTOPSY FINDINGS
EDICAL		non	re				1 _ YES	/	oc	OMPLETION OF CAUSE DEATH?
ME								/	1	YES 2 NO
	DID TOBACCO USE CONT	H YES NO UNCERTAIN				10		_ /		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		OF DEATH (Check only one)							
Sic	1 YES 2 NO	HOSPITAL:	ER/Outpetient 3 🗆		OTHER:	ne 5 🗆 Residence	8 Other (Specify)			
표	27. MANNER OF DEATN	28a. DATE OF IN (Month, Day,		86. TIME		JURY AT	28d. DESCRIBE HOW INJURY OCCURED			
BY	1 Natural 5 Pending 2 Accident Investigation	,			YES 2 NO					
	3 Suicide 6 Could not be	28s. PLACE OF I building, at	INJURY At home, c. (Specify)	, tarm, str	eet, factory, offic		28f. LOCATION (Stree City or Town, Stat	and Number	or Rural Rout	e Number,
	4 Nomicide determined						Only or rown, State	,		
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of m	y knowledge, death	occurred	at the time, date	and place, and due	to the cause(a) and m	enner as state	d.	
3										nd manner as stated.
5	MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.									
COMPLET		R				Ton Homes	4050	T		
BE CON	29b. SIGNATURE AND TITLE OF CERTIFIE	ashal				29c. LICENSE NUI	MBER	29d. DATE	SIGNED (M	onth, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED COMPLETED OF DEATH (ITEM 27) (Type, Print)

SOURCE THAT THE PROPERTY OF THE PROPE

EET HAGE

32. REISTRANG SIGNATURE

JELLA WILLIAM SIGNATURE

368 MILL S-31. DATE FILED (MONTH), Day, Year) OCT 2 8 1995

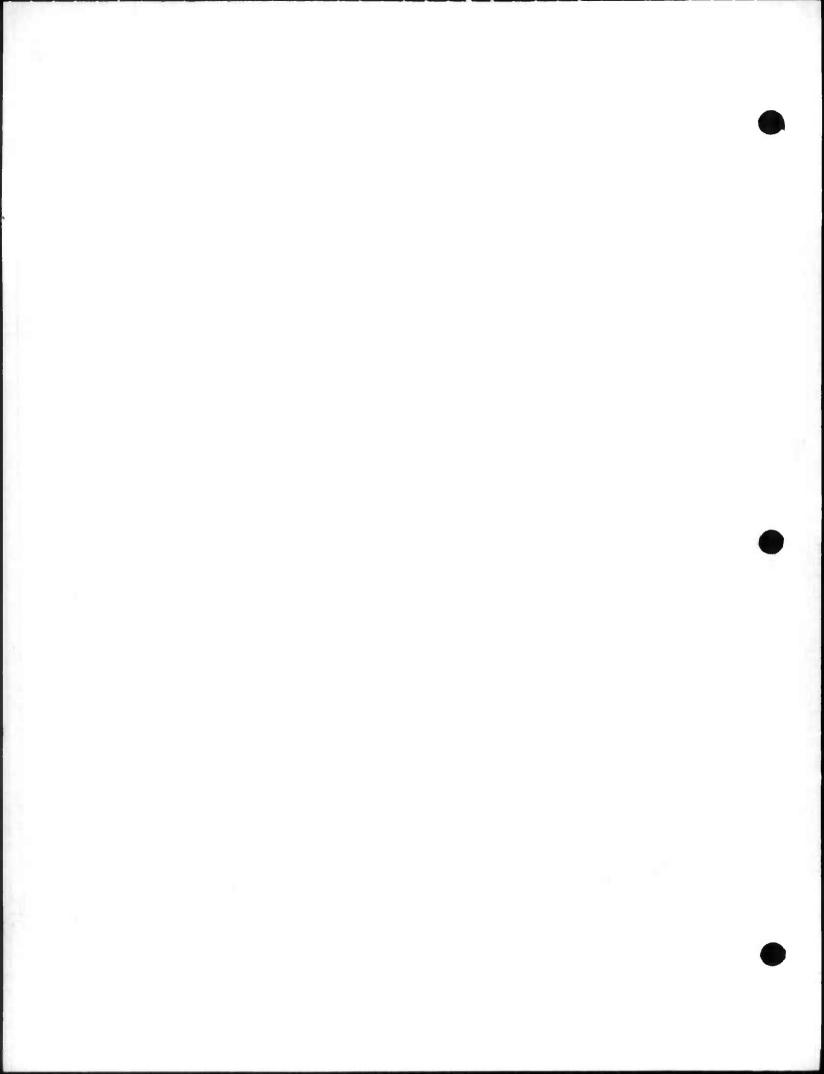
21740

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR			ICATE OF		REG. NO.	_			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	W	YEAR	3. TIME OF DEAT	тн
	Grace Catherin	ne Stout				Oct. 22,	1995	TEAR	1:15	ам
	The content of the same	1.1	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	PLACE (State or Fo	oreign
	219-14-7944	□ M 2 R F 88	YRS.	WONTHS DAYS	HOURS MM.	Oct. 22, 1	.907	Mar	ÿland	
	9a. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUN	TY OF D	EATH	
DIRECTOR	5332 Mt. Carmel Ch	urch Road		Keedy	sville		Wash	ning	ton	
JEC	10e. STATE 10b. COUNTY		10c. CI	Y, TOWN OR LOCA	TION				10d. INSIDE CITY	,
5	Maryland Wa	shington		Hager	stown				LIMITS?	NO
AL	10e. STREET AND NUMBER				f. ZIP CODE		10g. CITIZ	EN OF Y	VNAT COUNTRY?	
FUNERAL	17318 Amber Driv				21740		US	SA		
5	11. MARITAL STATUS 12 1 Never Married 2 Married	WAS DECEDENT EVER FORCES? 1 YES		13. WAS DEG	CENDENT OF HISPAN	IC ORIGIN? (Specify Year, Puerto Ricen, etc.)	or No-	14. RACE Black	- American Indi	en,
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR D	DATES		2 X NO Specify		- 1	Speci	w. White	
	15, DECEDENT'S EDUCATE	ON	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BUS	INESS/INDU	ISTRY	WHILE	
	(Specify only highest grade com Elementary/Secondery (0-12)	ollege (1-4 or 5 +)	(Give kind of life. Do NOT u	work done during mose retired.)	ost of working					
릴	9		aid			Special	. Educ	ati	on Schoo	01
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)			
BE (Robert Bart	on Carli	sle_		Anna	Schwinger				
2	19a. INFORMANT'S NAME (Type/Print)					loute Number, City or Town	, State, Zip (Code)		
-	Donna M. Bowman		17318	Amber D	rive Hag	erstown, M	aryla	and	21740	
	20a. METHOD OF DISPOSITION 1 C Burlet 2 Cremation 3 Removal		b. PLACE AND DATE			1 /	CATION — C			
- 1	4 Donation 5 Other (Specify)		Rose Hil.				ersto	wn,	Marylar	nd
	OF POWERAL SERVICE LICENS	numin	L L	Geral	ND ADDRESS OF FAC	ich 305	N. Po	tom	ac Stree	et
	Leura 01.11	WINAC	1	Funera	al Home	Hage	rstow	m,	Maryland	d
	23. PART i. Enter the diseases, or com ahock, or heart failure. List	plicetions that cause	d the death. Do	not enter the mo	de of dying, auch	aa cardiec or respi	retory erre	et,	Approximation interval B	
	IMMEDIATE CAUSE (Final	D		+		_			Onset and	
	disease or condition resulting in death)	DIVENT	ALCUCE	MIA	1 CLARE			6-	-12hres)
_		DUE TO (OR AS	A CONSEQUENCE O	F):	1.1764	YUPATH				
CERTIFICATION	Sequentially list conditions, b. —	DUE TO (OR AS	A CONSEQUENCE O	Pi C	(ac) com	7017 101	7/1	, a	547	
7	if any, leading to immediate cause. Enter UNDERLYING	Commance	1 Army	ny 1)1	(6001		5.	(Kanc	
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	CONSEQUENCE O	F):	1-100				(CYIL	
ᇤ	resulting in death) LAST									
	PART Ji. Other aignificant conditions of	ontributing to death i	out not resulting	in the underlyin	a ceuse alven in i	Boot 1 Dec ump au	ALITTORION	Lan		
ৰ	RESTRICTIVE +			0/56	g cause given in	PERFOR	MED?	240.	WERE AUTOPSY FI AVAILABLE PRIOR COMPLETION OF C	TO
MEDICAL	To street to	0.03/160	26 04-	0- 111	2175	1 YES 2	160		OF DEATH?	AUSE
Σ	DID TOBACCO USE CONTRIB	LITE TO CAUSE O	DE DEATH VI	S D NO N	UNCERTAIN		,		1 YES 2	NO
Y N	25. WAS CASE REFERRED TO MEDICAL	OTE TO CAUSE C	26. PLACE OF DEA		UNCEKIAIN	чЦ	^			
Sic		OSPITAL: Inpetient 2 ER/Out		OTHER:	e 5 🗆 Residence	N.6	hou	0/	Luci-	
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIN	E OF 28c. INJ	URY AT	28d. DESCRIBE NOW IN			mile	
BY P	1 Pending 2 Accident Investigation	(Month, Day, Year)	IN.	M 1 D	YES 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spe	/ — At home, ferm,	street, fectory, offic	•	28f. LOCATION (Street a	nd Number o	r Rural A	oute Number,	
	4 Nomicide determined	, , , , ,				City or Town, State)				
٦ ا	290. CERTIFIER (Check only	: To the best of my know	riedga, death occurr	ed at the time, date	and place, end due	to the cause(a) and man	ner as atated	d.		
COMPLETED	one) 2 MEDICAL EXAMINER: O								and manner as si	tated.
	295 A GNATURE AND TYPLE OF CERTIFIER	1975			29c. LICENSE NUM	PER	29d. DATE	SIGNED	(Month, Day, Year)	
O BE	MP MW FAM	nicy Pit	4SICIA	~	1) 1704	. /	D /0	1/24	199	
f	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type		, 1	1/	-	-	/ >	
	METER E METE	Non, MI	197	NonTHO	IN HUE	- HMGG	TTELL	da	MA	
1	31_DATE_FILED (Month, Day, Year)	#2. REGISTRADE SIGN	ATURE		, VI	1111-	3			

BALTIMORE, MARYLAND 21215-0020



death. Page 6 may be retained by the hospital or attending physician BALTIMORE, MARYLAND 21215-0020

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DIRECTOR

FUNERAL

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CERTIFICATION

MEDICAL

PHYSICIAN:

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30. NAME AND ADDRESS

31. DATE FILED (Month

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1995

32. DEGISTRAR'S STONATURE

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DIVISION OF VITAL RECORDS, P.O. BOX 6876

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201100	tending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-iransit permit. Pages 1	giene	other
	ttendi	tal Hy	, Or
200	the a	J Men	Injul
15	led by	Ith an	any
HOLING OF THE COUNTY OF THE CO	UNERAL DIRECTOR: After this certificate has been signed by the attendin	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remova	ITANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at o
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200	Sertific	the S	0
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2	After	death	s ma
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3	FUN	with	TAN

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR NOV. 4 1995 JAMES MAJOR THOMPSON 10:08 am 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign JULY 6 1909 HOURS MARYLAND 86 Ty M 2 F 213-01-7998 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNT 10d. INSIDE CITY LIMITS? 1 PYES 2 NO MARYLAND ANNE ARUNDEL CHURCHTON 10e, STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? USA 20732 5650 DEALE CHURCHTON ROAD 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES II yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BLACK 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) E.A.&J.O. CRANDALL PILE PILE DRIVER 16. MOTHER'S NAME (First, Middle, Meiden Surname) 17. FATHER'S NAME (First Middle Last) DORACE HOLLAND JAMES THOMPSON 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5625 SHADY SIDE RD. CHURCHTON, MD. 20733 EDITH L. GROSS 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 1X Burial 2 Cremation 3 Removal Irom State
4 Donation 5 Other (Specify) 11/8/1995 LAKEMONT CEMETERY DAVIDSONVILLE, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. み Keese 821 WEST ST. ANNAPOLIS, MD. 21401 23. PART t. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, auch Approximate shock, or heart fallure. Liet only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in daeth) DUE TO (OR AS A CONSEQUENCE OF Sequentielly ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST P(RT) Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMEO? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 ma. 0 1 TYES A INO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL > OTHER 1 YES 2 THO Inpetient 2 ER/Outpetient 3 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28d. GESCRIBE HOW INJURY OCCURED Natural 2 M Accident 5 Pending investigation 1 YES 2 NO 28e. PLACE OF INJURY — etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the bests of exemination and/or investigation. In my opinion, death occurred at the time, date and place SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day LICENSE NUMBER 1

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked. or Item 23 shows any Injury, or other traumatic event, the medical axaminer must be notified at once.

	REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO).	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Thayer	Talbott	Tucke	r		November	1995 YEAR	6:19A M
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		HPLACE (State or Foreign
	220-44-1200		94 YRS.	MONTHS DAY		(Month, Day, Year)	Coun	try)
		- Table 1	74			Feb 18 19		
~	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOW	N OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH
Ö	Ginger Cove Heal	th Care Cen	ter	Annap	olis		Anne	Arundel
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	v						
DIRECTOR			10c. CIT	Y, TOWN OR LO				10d. INSIDE CITY LIMITS?
		Arundel		Anr	apolis			1 _ YES 2 WO
¥	10e. STREET AND NUMBER				10f. ZIP CODE			WHAT COUNTRY?
FUNERAL	5206 River Cres	cent Drive			2140)1	United	l States
5	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	e or No.— 14. RAC	E - American Indian,
	1 Never Married 2 Married	FORCES? 1 YES	DATES		specify/Cuban, Maxic ES 2 NO Speci	an, Puarto Rican, atc.)	Spe	ck, White, atc.
BY	3 Widowed 4 Divorced					.,.	3,50	white
밆	15. DECEDENT'S EDU (Specify only highest grade	CATION (Completed)	18a. DECEDENT'S	USUAL OCCUPA	TIDN	16b. KIND DF BU	SINESS/INDUSTRY	
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT us	vork done during se retired.)	most or working			
<u>_</u>		4	Officer	/Capta	n	Milita	rv/USN	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden		
EC	Arthur Warren Tu	cker				Talbot _t		
00	19a. INFORMALIT'S NAME (Type/Print)	CKOT	19h MAIL ING	ADDRESS (S)		Route Number, City or Tow		
2	Jean T. Lochner							1 01 101
						Annapolis		
	20g. METHOD OF DISPOSITION 1 Disposition 3 Removed	ovet from State Q6	b. PLACE AND DATE (pringlery, crematory or o	of DISPOSITION	Name of	DATE 20c. LC	CATION — City or T	own, Stata
	4 Donation 5 Other (Specify)	1	JS Naval	4cademy	Cemetery	/1/6/95 A	NNAPOLIS,	, MD.
	21. SIGNATURE OF FUNERAL SERVICE LIC	SENSEE /	//	22. NAME	AND ADDRESS OF F	John M.	Taylor E	uneral Home
	tunales.	1 1. 4	21	147	Duke of i	Gloucester	St Anna	enolis MD
	23. PART I. Enter the diseases, or o	complications that cause	ed the death. Do a					
	shock, or heart fellure.	List only one cause on	asch lina.	ot anter tha r	node or dying, suc	n as cardiac or resp	iratory srrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disesse or condition	Ro	- 1 6	,	/		,	Onset and Death
	resulting in death)	a	and 5	TEM	10	FARCTIO	N	2/1/15
		DUE TO (OR AS	A CONSEQUENCE OF	7:				
z	Sequantially list conditions,	b	TA-SC	VI				year
CERTIFICATION	if sny, laading to immediata	DUE TO (OR AS	A CONSEQUENCE OF	7:				0
2	CAUSE (Disease or injury	с						
E	that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):				
E	resulting in death) LAST	d						
	DART II Other classificant and dis-							
DICAL	PART II. Other significant condition	s contributing to death	but not resulting	n the undariy	ng causa given in	Part I. 24a. WAS AN PERFOR		MAILABLE PRIOR TO
	acet fr	own	MIL	10	0000	1 □ YES 2		COMPLETION DF CAUSE DF DEATH?
WE	arrend	Emp	les R	-/leg			//	1 TYES 2 NO
1 = 1	DID TOBACCO USE CONTR			S D NO	UNCERTAI	N [
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE DF DEAT					
1 25	EXAMINEIT? 1 Tes 2 XXX	HOSPITAL: 1 Inpatient 2 ER/Out	notion 2 Dos	OTHER:	ome 5 🗆 Residence			
=	27. MANNER OF DEATH	28e. DATE DF INJURY	28b, TIM					
	1 Naturel 5 Pending	(Month, Day, Year)	200. TIM	URY Y	NJURY AT YORK?	28d. DEŞCRIBE HOW I	NJURY OCCURED	
BY	2 Accident investigation				YES 2 ND			
<u> </u>	3 Suictile 8 Could not be 4 Homicide determined	28e. PLACE DF tNJUR building, etc. (Spi	Y — At home, farm, secify)	treet, factory, of	lice	28t. LOCATION (Street : City or Town, State)		Route Number,
COMPLETED	AND SAME SAME							
급	29e. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of my know	wledge, death occurre	d at the time, da	ta and placa, and due	to the cause(a) and mai	nner as stated.	
N		R: On the basis of examination						a) and menner as stated.
- II	296. SIGNATURE AND TITLE QF CERTIFIER		1					
1	TATA C	V DX	And	0	29c. LICENSE NU			(Month, Day, Year)
0		1000	W 1 1/2	/	D21438	5	Novemb	er 1 1995
	36. NAME AND ADDRESS OF PERSON WHO	,						
	Michael J. LaPent	a, M.D. 705	Welvin A	venue A	nnapolis,	MD 21401	(410-268	-0755)
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE					
1 1	NOV 02 19	45 de 18	sulson Randa	Z				

11-

DIVISION OF VITAL RECORDS, P.O. BOX 68760

PHYSICIA	lled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ALTENDING PHY	TO THE FUNERAL DIRECTOR; After this	be filed within 72 hours after death wil	IMPORTANT: If Item 28 is marke

	REGISTRAR		CE	KIIF	CATE OF	DEATH		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE O	F DEATH			3. TIME OF DEATH
1	James Louis		Thomas			October 30, 1995					
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		IF UNDER 1 YEAR	w things at the			5U, I		6:35 a M
		1 🔀 M 2 🗆 F			MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		Day, Year)		Count	
- 3	214-30-0797		81	YRS.			Januar	y 22,	1914	Mary	land
	9a. FACILITY NAME (If not institution, give at	,				OR LOCATION OF D	EATH		9c. COU	NTY OF D	EATH
OH	Route 238 Box 13	32 (Resi	dence)		Cha	ptico			St	. Ma	ry's
5	RESIDENCE OF DECEDENT										
DIRECTOR	10a. STATE 10b. COUNTY				, TOWN OR LOCAT	LION					10d. INSIDE CITY LIMITS?
ō	Maryland St.	Mary's		0	haptico						1 YES 2 X NO
A	10e. STREET AND NUMBER				101	f. ZIP CODE			10g. CIT	IZEN OF Y	WHAT COUNTRY?
R	Route 238, P.O.	Box 132			1	20621				S.A	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVED IN ILE ADS	HED	40 3000 000			V - 1			
교	1 Never Married 2 Married	FORCES? 1	YES 2 N		II yes, sp	CENDENT OF HISPA ecify Cuban, Maxic	en, Puerto Ric	(Specify Yes an, atc.)	or No—	14. RACI Blaci	E — American Indian, k, White, etc.
B₹	3 🖾 Widowed 4 🗌 Divorced	IF YES, GIVE W	AR OR DATES		1 🗌 YES	2 NO Specif	ly:			Spec	"y: Black
	15. DECEDENT'S EDUC				_!						DIACK
2	(Specify only highest grade	completed)	(Gh	ve kind of w	USUAL OCCUPATION ork done during mo	ON ost of working	16b, K	IND OF BUS	SINESS/INI	DUSTRY	
3	Elementary/Secondary (0-12)	College (1-4 or 5+)) Ino.	Do NOT us				П.			
₹ I	5th grade			Fai	mer			Far	m		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Mid	idle, Maiden	Sumame)		
BE	Louis Al	lfred	Thoma	as		Mary]	Louis	e	Ma	arshall
	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS (Street a	and Number or Rural	Route Number	City or Tow	n. State Zir	n Code1	
2	Mary B. Allen					Mechanicsv					
	20s. METHOD OF DISPOSITION				F DISPOSITION (Na			<u> </u>			
	1 🖾 Burial 2 🗆 Cremation 3 🗆 Ramo	oval from State	cemetery, cren	natory or ot	her place)	ry Nov. 3	1005	20c. LO	CATION —	City or To	wn, Stata
1	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	euere /	I Queen o	or rea							
	6-007		1.	1	Mattin	nd Address of FA	diner diner	Fune	ral	Home	. P.A.
	Michael &	Dan	diner)							and 20650
	23. PART E Enter the diseases, or co	omplications that	caused the dea	th Do n							Approximate
	About no board follows 1										
	shock, or heart failure. L	ist only one caus	se on each line.		ot unter the mo	da bi dyilig, suc	ii as cui dia	c or reap	atory an	rest,	intarvai Between
	IMMEDIATE CALLSE /Final	lst Dnly Dna caus	se on each line.								
	IMMEDIATE CALLSE /Final	lst Dnly Dna caus	se on each line.								intarvai Between
	IMMEDIATE CALLSE /Final	ist only one caus	se on each line.								intarvai Between
NC	IMMEDIATE CAUSE (Final disease or condition resulting in death)	i. Mef	OR AS A CONSEC	UENCE OF	Prost						intarvai Between
TION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	i. Mef	se on each line.	UENCE OF	Prost						intarvai Between
ICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSECU	UENCE OF	Prost						intarvai Between
FIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEC	UENCE OF	Prost						intarvai Between
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSECU	UENCE OF	Prost						intarvai Between
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AL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSECUTOR AS A CONSE	UENCE OF	Prost	late	Can	CONC	AUTOPSY	a	Interval Between Onset and Daath 4 92
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BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be	DUE TO (1) DUE TO (2) DUE TO (3) DUE TO (4) DUE TO (6) DUE TO (6) DUE TO (6) DUE TO (7) DUE TO (7) DUE TO (8) DUE TO	OR AS A CONSEO OR AS A CONSEO OR AS A CONSEO OR AS A CONSEO JSE OF DEAT 28. PLACE ER/Outpetlent 3 (NJURY — At hor	UENCE OF UENCE OF UENCE OF EAUITING IN THE OF DEAT	The undarlying The undarlying The Check only one) OTHER: A Nursing Hom OF 28c. INJI WO 1 1	G cause givan in UNCERTAIL 5 K Raaldenca URY AT RK7 //ES 2 NO	Part I. 2. N	4a. WAS AN PERFOR	AUTOPSY MED? DYNO	24b.	interval Between Onset and Daath 4 1 92
BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pending investigation	DUE TO (1) DUE TO (2) DUE TO (3) DUE TO (4) DUE TO (6) DUE TO (6) DUE TO (6) DUE TO (7) DUE TO (7) DUE TO (8) DUE TO	OR AS A CONSECTION OF AS A CONSE	UENCE OF UENCE OF UENCE OF EAUITING IN THE OF DEAT	The undarlying The undarlying The Check only one) OTHER: A Nursing Hom OF 28c. INJI WO 1 1	G cause givan in UNCERTAIL 5 K Raaldenca URY AT RK7 //ES 2 NO	Part I. 2. N	44. WAS AN PERFOR YES 2	AUTOPSY MED? DYNO	24b.	interval Between Onset and Daath 4 92
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DITHE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE	TO THE	be filed	IMPOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	CERTIFIC	ATE OF	DEATH	REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	MV Y	3. TIME OF DEATH		
	JOHN GEORGE TIEDEMANN				OCT 30		2:44 A	M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreig Country)	n	
	578-34-7998 ¹¼™²□F 6°	7 YRS.	ONTHS DAYS	HOURS MIN.	12-12-		Washington	, D.	
~	9a. FACILITY NAME (If not institution, give street and number)	91		OR LOCATION OF DE	ATH	9c. COUNT	Y OF DEATH		
0	NATIONAL NAVAL MEDICAL CENTER		BEI	HESDA		1	MONTGOMERY		
EC	10a. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCA	TION			10d, INSIDE CITY		
DIRECTOR		Wash		n, D.C.			1 YES 2 NO	,	
AL	10e. STREET AND NUMBER			f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?		
FUNERAL	2938 McKinley St., N.W.		2	0015-12	262		U.S.A.		
J.	11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2				IIC ORIGIN? (Specify Yon, Puerto Rican, atc.)	a or No-	RACE — American Indian, Black, White, atc.		
ВУ	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES		1 TYES	2 X NO Specify	r.		Specify: White	- 1	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	DECEDENT'S US	k done during me	ON ost of working	16b. KIND OF B	JSINESS/INDUS	STRY		
E	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use n							
MP		Manage:	ment				1 Service	_	
00	17. FATHER'S NAME (First, Middle, Last) Berthold D. Tiedemann				ME (First, Middle, Maide Gootee				
BE				·				_	
0	19a. INFORMANT'S NAME (Type/Print) Sheila M. Tiedemann				Route Number, City or To		tonD.C.200	115	
		ACE AND DATE OF			•	_		113	
	20a. METHOD OF DISPOSITION 1	ropoli	tan C	remator	1 / 1 9 5 20c. L	lexan	dria, Va.		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	-64	²² TYAME (MAORES OF A	ERAL , HO	ME 25	4 CARROLL	ST	
Э	Muchant of Tregler		N.W	. WASHI	NGTON, D	.C. 2	0012		
NOI	IMMEDIATE CAUSE (Final disease or condition resulting in death) LEUKEMIA DUE TO (OR AS A CO Sequentially list conditions, If any, leading to immediate						Onset and D	eath	
CERTIFICATION	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
F	resulting in death) LAST								
	DART II Ohbus algoridisent sanditions santulbuting to death but	nat acculting in	Ab a seed solule	in anno abian In	Post I as una	N. ALETTO POW	Total MEDIC ALTROPOL FINE	W100	
DICAL	PART II. Other significant conditions contributing to death but of	not readiting in	tha dilderlyii	ig cause givan in	PERF	N AUTOPSY DRMED?	24b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION DF CAU		
	·				1 X YES	2 NO	OF DEATH?	170	
ME	DID TODA COOLICE CONTRIBUTE TO CAUCE OF	DEATH VEC		T IN ICEDIAN			1 TYES 2 NO		
N N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF E	PLACE OF DEATH			NLI				
2	EXAMINER? HOSPITAL:	_ (THER:						
PHYSICIAN:	1 VES 2X NO 1 X Inpetiant 2 ER/Outpetia 27. MANNER OF DEATH 28e. DATE OF INJURY	28b. TIME		JURY AT	8 U Other (Specify) 28d. DESCRIBE HOW	IN ISIBY OCCU	IREO		
BY PH	1 Netural 5 Pending (Month, Day, Year) 2 Accident Invastigation	INJUF	Y W	YES 2 NO	200. DESCRIBE NOV	moon occ	INED		
	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — building, etc. (Specify)	At home, term, str	net, tectory, offi	ca	28t, LOCATION (Stree City or Town, Star		r Runsi Route Number,		
Ë	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge	e, death occurred	at the time, dat	a and place, and due	to the cause(a) and a	anner sa states	1.		
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the beals of examination and							ed.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER MT	>		29c. LICENSE NU		29d. OATE	SIGNEO (Month, Day, Year)		
5	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) NATIONAL NAVAL MEDICAL CENTER								
	JANET M. NICHOLS, LT, MC, USN	3019	97/1-	BETHESTA	MD 20889	-5600			
	31. DATE FILEO (MORIN, Dey. Year) 32. REGISTRAR'S SIGNATU AND 1995 34. REGISTRAR'S SIGNATU Fully Shurdson	aviall.							
	NOV 02 1995 Julia dandsont	CH DANA, 17	-4		33.55 Pub				

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	FOR STATE REGISTRAR	ATE OF MAR		PARTMENT		EALTH AND N		GIENE			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DE	EATN			3. TIME OF DEATN
3	Vera Lea	Tangred	li				MONTH October	29	19	995	10:00 P M
	4. SOCIAL SECURITY NUMBER 5. SE	X 6. A	6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24				7. DATE OF BIRTH 8.			8. BIRTH	PLACE (State or Foreign
	492-24-3039	M 2 🖾 F	68 YF	RS. MONTHS	DAYS	HOURS MIN.	March	10,19	927	May,	0klahoma
	9a. FACILITY NAME (If not institution, give street and	d number)		9b. CITY	, TOWN O	R LOCATION OF DE				NTY OF DE	
OR	Holy Cross Hospital			Si	lver	Spring			Mo	ntgo	mery
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY		140.	. CITY, TOWN							40.4 MINING ATTY
I I			100	Rockv		ON					10d. INSIDE CITY LIMITS?
	Maryland Montgo	шегу		ROCKV		ZIP COOE			10~ CITI	TEN OF W	1 TYES 2 K NO
RA	13007 Vandalia Drive				101.	20853			10g. CI I	USA	HAI COUNTHY?
FUNERAL		AS DECEOENT EVE	O IN IL C ADMICO	1 40	W# 0 050	ENDENT OF NISPAN	uc onione m-	- 14 . V	- N- I		- American Indian,
	1 Never Married 2 X Married	ORCES? 1 Y	ES 2 X NO		If yes, spe	city Cuban, Maxice	n, Puerto Ricen,		- ON	Black	, White, etc.
BY	3 Widowed 4 Divorced	YES, GIVE WAR O	H DATES		1 YES	2 X NO Specify	/:			Specif	White
G	15. DECEDENT'S EDUCATION			NT'S USUAL O			16b. KINC	OF BUSIN	ESS/INC	USTRY	
<u>L</u>	(Specify only highest grade completing (0-12) Elementary/Secondary (0-12) College	ege (1-4 or 5 +)	life. Do N	of work done IOT use retired.)							
APL.	12		Cafet	eria M	lanag	er	Mon	tgome	ry	Coun	ty Schools
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle,	Maiden Su	rname)		THE PARTY
BE (Claude M. Burnam					Nola	Byram				100
TO B	19a. INFORMANT'S NAME (Type/Print)					nd Number or Rural F					
-	Nicholas Tangredi					a Drive,					
	20a. METHOD OF DISPOSITION 1 X Buriel 2 C Cremation 3 C Removal fr	om State	20b. PLACE AND D			me of netery 1:		20c. LOCA			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE		Gate of			D ADDRESS OF FA	1	211.	ver	Spri	ing, MD
	· (#4 \\\(\)/2	0				cis J. C		Fune	ral	Hom	e. Inc.
	Cloud Str	mcl									.MD 20901
	23. PART I. Enter the diseases, or complianock, or heert fellure. List o			Do not enter	r the mo	de of dying, suci	h aa cerdlec	or reapira	tory an	reat,	Approximeta Interval Batween
	DATE OF THE PARTY				1	?	-				Onset and Death
	disease or condition a				-	BLE	ED				Days
		OUE TO (OR	AS A CONSEQUEN	CE OF):							
S	Sequentielly list conditions, b	DUE TO (OR	AS A CONSEQUEN	CE OEI-							
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	502 10 (011)	AS A CONSECUEN	or or j.							
임	CAUSE (Disease or injury that initieted events	DUE TO (OR	AS A CONSEQUEN	CE OF):							
E	resulting in death) LAST										
						dio.					
Ä	PART II. Other algnificent conditions con					cause given in	Part i. 24e.	PERFORM		246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
B	DHYPERTENSION					. 0.=	10	YES 2X	NO		OF DEATH?
ME	3 POLYMYOSITIS		NOES	11-0		LURG					1 TYES 2 NO
ä	DID TOBACCO USE CONTRIBU	TE TO CAUSE		YES L		UNCERTAIL	NU				
5		SPITAL:		OTHE							
PHYSICIAN: MEDIC		Inpetient 2 ER/ 28s. DATE OF INJU		b. TIME OF	rsing Hom 28c, INJ	e 5 🗋 Residence	6 Other (Spe 28d. OESCRIB		HIEV OO	CUREO	
=	1 🔀 Natural 5 🔲 Pending	(Month, Day, Ye	ar)	INJURY M	WO	RK7	28d. OESCHIE	E HOW INJ	JURY OC	COMEO	
BY	2 Accident Investigation 3 Suicide 8 Could not be	26s. PLACE OF INJ	IURY — At home, 1	lerm, street, fac			281. LOCATION	N (Street and	d Numbe	r or Rural I	Route Number
	4 Homicide 8 Could not be	building, atc.	(Specify)				City or Tox				
COMPLETED	298. CERTIFIER	Yn the heat of my b	nominator death o		4-1-						
MP	(Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On										a) and menner as stated.
	295-SIGNATURE AND TITLE OF CERTIFIER										
BE	(Selection of the Control of the Con	ात्र पर				29c. LICENSE NUI	10	1	29d. DA1	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COR	PLETED CAPISE OF	F DEATH (ITEM 27)	(Time Print)		NC48	ال			2	20122
	Bruce W. Zinsmeiste				C+	#601 04	11,,,,,,	m no d	- 34T	200	10 (100
		32. REGISTRAR'S	SIGNATURE	meron	DL.	#601 Si	river S	pring	Z, MID	209	10-4183
	NOV 01 1995 July	Davidson-1									
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	1 - STATE REGISTRAR	STATE OF MARY		MENT OF HE		MENTAL HYGIEI REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY YE	3. TIME OF DEATH	
	John Alexand	er Toop					29, 199		
	4. SOCIAL SECURITY NUMBER		MA .		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. E	NRTHPLACE (State or Foreign country)	
	089-30-5569 9e. FACILITY NAME (If not institution, give:	1 M 2 F	92 YRS.	b. CITY, TOWN OR	3-310	Nov. 14,	1902 C	anada OF DEATH	
DIRECTOR	15832 Bradford Dr	ive		Laurel			Prince	George's	
E	10a. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCATIO		W. F. W.		10d. INSIDE CITY LIMITS?	
		tgomery Sil			Spring			1 TYES 2 KNO	
FUNERAL	106. STREET AND NUMBER			101, 2	IP CODE			OF WHAT COUNTRY?	
N.	2207 Prichard Ro				20902		Can		
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	If yes, spec	ty Cuban, Maxica	NIC ORIGIN? (Specify Yan, Puerto Rican, etc.) y:		RACE — American Indian, Black, White, atc. Specify: nite	
0	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S US	BUAL OCCUPATION	of working	16b. KIND OF BI	JSINESS/INDUST		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use i	retired.)	or working				
COMPLETED		4 Clergyman				Relig			
00						ME (First, Middle, Maide	n Surname)		
BE	Arthur Ernest Toop					ret Lett			
5	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Toop Weigle 15832 Bradford Drive Laurel, Maryland 207								
-	Donna Toop Weigl				_			20707	
	20a. METHOD OF DISPOSITION 1 St Buriel 2 Cremation 3 Rem	noval from Stata Co	b. PLACE AND DATE OF imetery, crematory or othe	r place)	11	/5/95	DCATION City		
	4 Donation 5 Other (Specify)		George Wasl				lphi, M		
	21. SIGNATURE OF FUNE MAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc.								
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS Arterios DUE TO (OR AS	VE Heart F A CONSEQUENCE OF: Clerotic F A CONSEQUENCE OF: A CONSEQUENCE OF:		sease			1 Year	
ERT	resulting in death) LAST								
PHYSICIAN: MEDICAL C	PART II. Other algnificent condition	na contributing to deeth	but not reaulting in	the underlying	ceuse given in	Part I. 24a. WAS A PERFC 1 PYES	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL			26. PLA	E OF DEATH (Ch	eck only one)			
SIC	EXAMINER? 1 YES 2 X NO	HOSPITAL: 1 □ Inpetient 2 □ ER/Ou		THER:	- 15-1	6 Other (Specify)			
1 4	27. MANNER OF DEATH 1 X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJUI	TY AT	20d. DESCRIBE HOW	INJURY OCCURE	O	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	26s. PLACE OF INJUF building, atc. (Sp	RY — At home, term, streedily)	eet, factory, office		261. LOCATION (Street City or Yown, State		ural Route Number,	
COMPLET	enel	ICIAN: To the best of my kno						use(a) and manner as stated.	
TO BE C	296. SIGNATURE AND TITLE OF CONTIFIE	amo			D219	MBER 10	≥ 10/	30/95	
-	leter & Shere	rmp 3	947 Ferro	ine Dr.	Whear	ton, mp	2090	06	
	31. DATE FILED (Month, Day, Year) NOV 03 1995	Julia Dhuch	ox-Rardall						

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

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5. SEX

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6. AGE on yrs. lest birthday

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83 577-05-0245 1 🔀 M 2 🗌 F page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 623 Gist Avenue 20910 nours after death. Page 6 may be retained by the hospital or attending physician. 12, WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES

WW II 11. MARITAL STATUS 1 Never Married 2 Married 1 TES 2 X NO BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 11 Paymaster notified at once. 17. FATHER'S NAME (First, Middle, Lest) Louis N. Tress BE 19a. INFORMANT'S NAME (Type/Print) 5 Lydia S. Tress 623 Gist Avenue, Silver Spring, MD e 20s. METNOD OF DISPOSITION
1 Street 2 Cremetton 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of this certificate has been signed by the attending physician and completely filled in by the funeral director, with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. rked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must Cedar Hill Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 9 central 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final 24 disease or condition acute within 2 o Cordial my resulting in death) DUE TO (OR AS A CONSEQUENCE OF): the death certificate be executed PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. that OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF marked, 1 Netural 5 Pending 1 YES 2 NO В After death 2 Accident Investigation D THE FUNERAL DIRECTOR: After the filed within 72 hours after dea MPORTANT: If item 28 Is in 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 8 Could not be determined COMPLETED 4 Homicide 29e, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner se stated. (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. IMPORTANT: 29b. SIGNATURE AND TITLE OF CERTIFIED 뿚 BE 2 23 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) John F. Tauber M.D. 8218 Wisconsin Avenue, #318 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 03 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 2. DATE OF DEATN 3. TIME OF DEATH YEAR OCT A 7. DATE OF BIRTH
(Month, Day, Year)
July 26,1912 IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Maryland 9c. COUNTY OF DEATH Montgomery 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify Specify. White 16b. KIND OF BUSINESS/INDUSTRY Pepco 18. MOTNER'S NAME (First, Middle, Maiden Surname) Mary Ellen Kraft 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 DATE 20c. LOCATION — City or Town, State 11/3/95 Suitland, MD Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901 Approximate Intervei Betwe **Onset and Death** hz 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 NO OF DEATH? 1 TES 2 NO 28. PLACE OF DEATN (Check only one) 28d. DESCRIBE NOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 081 001 Bethesda, MD 20814-3107

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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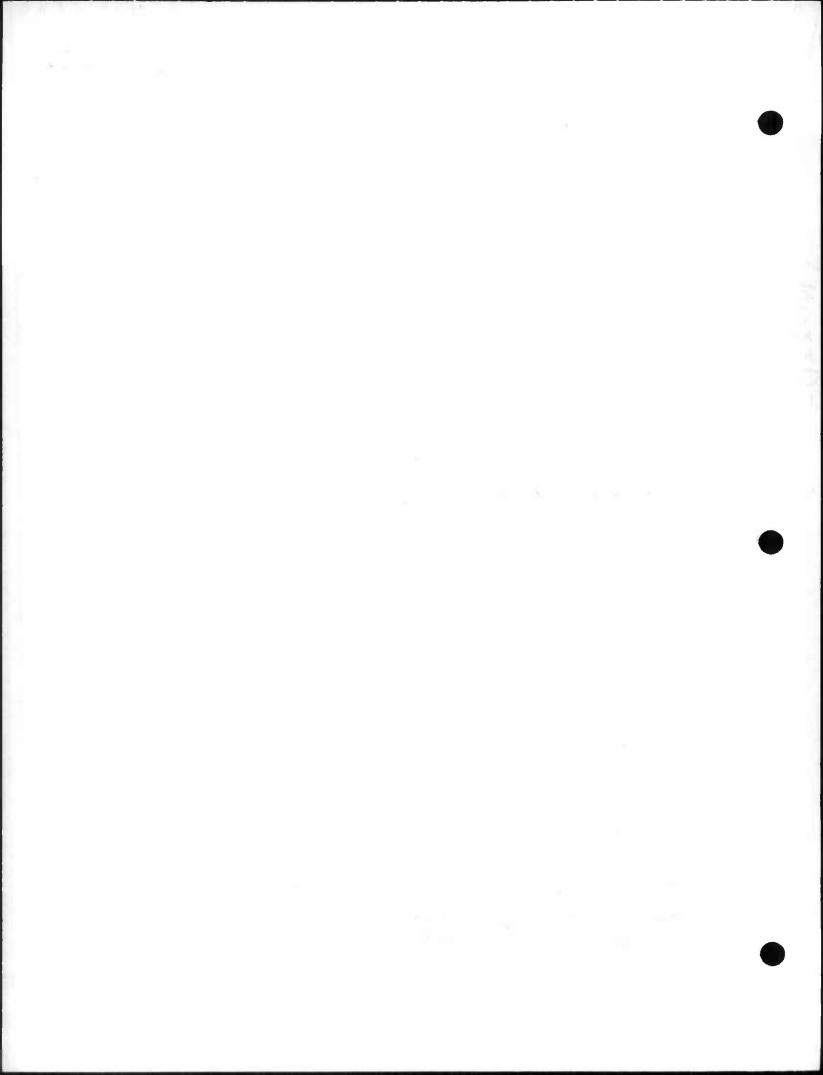
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			WENTAL HYG			, 100	0
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	ГН	3	TIME OF DEA	TN
	Gloria L. Tra	vers				Octobe:	r 25, 19	995 5	:10	Ам
		SEX 6. AGE (_	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTI (Month, Day, Ye	N T	-	ACE (State or F	oreign
	219 20 1103		67 YRS.	ONTHS DAYS	HOURS MIN.	December			yland	
	9a. FACILITY NAME (If not institution, give street	and number)		•	OR LOCATION OF DE	ATH	9c. COUN	TY OF DEA	TN	
<u></u>	Deer's Head Cent	er		Salis	bury		Wicor	nico		
ធ្ន	RESIDENCE OF DECEDENT 108. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION						Ta	Dd. INSIDE CIT		
<u></u>	Maryland Wicon	nico	Salisbury						LIMITS?	
ا دِ	10e. STREET AND NUMBER				f. ZIP CODE		10a, CITI2		AT COUNTRY?	NO
FUNERAL DIRECTOR	Bldg. 318, Apt.	101, Glenn	Garden Ap	ts.	21801			JSA		
3	11. MARITAL STATUS 12	. WAS DECEDENT EVER IN			ENDENT OF NISPAN			14. RACE -	- American Indi	len,
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	☐ YES 2 ☑ NO If yes, specify Cuban, Maxican AR OR DATES 1 ☐ YES 2 ☑ NO Specify:			in, Puarto Rican, etc.) Black, Whit			Vhita, etc.	
									ite	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade corr	npleted)	(Give kind of wo	SUAL OCCUPATI rk done during mi retired.)	ON ost of working	16b, KIND O	F BUSINESS/INDI	JSTRY		
ן ב	Elementary/Secondary (0-12) C	Coffege (1-4 or 5+)	Beautici			Beau	tv			
8	17. FATNER'S NAME (First, Middle, Last)				18 MOTNER'S NA	ME (First, Middle, M.				
	Lester	Parsons			Elizab			cice		
BE	19e. INFORMANT'S NAME (Type/Print)		196. MAILING A	DDRESS (Street	and Number or Rural F	Route Number, City o	r Town, State, Zip	Code)		
임	William H. Travers	s Jr.	Bldg.	318,Apt	.101,Gle	nn Garde	ens Apts	.Sal	is.,MD	2 180 1
	20a. METNOD OF DISPOSITION 1∑ Burlal 2 ☐ Cremation 3 ☐ Removal	from State 20b.	PLACE AND DATE OF	DISPOSITION	ame of	OATE 20	c. LOCATION — C	ity or Town	, State	
	4 Donation 5 Other (Specify)	Sp	etery, crematory or other ringhill Me	emory Gar	dens	10/27 I	Hebron,	MD		
- 1	21. SIGNATURE OF PUNERAL SERVICE LICENS	ALE .			ND ADDRESS OF FAC Lloway Fu		nme			
	1 David (socamos	>		l Snow Hi			iry,M	D 2180	1
	23. PART I. Entar tha diseases, or com shock, or heart fallure. List	pilcations that caused	tha death. Do no						Approxim	ata
1	IMMEDIATE CAUSE (Final	only one cause on as	ich iina.						Onset and	
	disease or condition resulting in death)	Ovarian C	arcinoma						l Yr	
		DUE TO (OR AS A	CONSEQUENCE OF):							
NO I	Sequantially list conditions, b	DUE TO (OR AS A	CONSEQUENCE OF):						-	
Ě	if any, leading to immediata cause. Entar UNDERLYING		oonororor or j.						İ	
	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	resulting in death) LAST									_
5	PART II. Other significant conditions of	ontributing to death h	ut not resulting in	the underlyin	a cause alvan la	Part I Day No	S AN AUTOPSY	T 445 W	ERE AUTOPSY F	
3		or a desired	at not readiting in	the underlyin	A cansa Aisan in	PE	RFORMED?	A	MILABLE PRIOR DMPLETION OF	TO
						¹ □ YI	ES 2 X NO	O	F DEATN?	171-2
Σ	DID TOBACCO USE CONTRIB	LITE TO CAUSE O	F DEATH YES	ПИОГ	UNCERTAIN			1	YES 2	NO
N N	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		1 OIACEKIAII	1 1 1				
SIC	EXAMINER? 1 YES 2 NO 1	OSPITAL: XInpatient 2 - ER/Outp	etient 3 DOA 4	OTHER:	ne 5 🗆 Residence	6 Other (Specify)			
PHYSICIAN: MEDIC	27. MANNER OF OEATH	26a. OATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c. IN.	JURY AT DRK?	28d. OESCRIBE H		UREO	-	
8	1 Netural 5 Pending 2 Accident Investigation				YES 2 NO			1		- 11
- 4	3 Suicide 8 Could not be 4 Nomicide detarmined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, str ify)	eet, factory, offic	•	28f. LOCATION (S City or Town,	treet and Number (State)	or Rurel Rou	te Number,	
COMPLETED	29a. CERTIFIER (Check only one)									
5	2 MEDICAL EXAMINER: 0	n the basis of examination	and/or investigation,	In my opinion, o	leath occured at the	time, date and plac	e, and due to the	cause(s) a	nd manner as s	itated.
BE	29b. SIGNATURE AND THE OF CERTIFIER	2 10	1	L #	29c. LICENSE NUM	IBER	29d. DATE	SIGNED (M	onth, Day, Year)	
2	Vegena	A WW	compositions	D ens	D33905		1 /	0/2	5-195	-
	30. NAME AND ADDRESS OF PERSON WHO CO				3/2	21002 20	110			
	V.A. Dulany, M.D., Cl 31. DATE FILED (Month, Day, Year)			allsbu:	ry, Md.	21802-20	ŊΤΩ			
	OCT 26 1995	32 AEGISTRAR'S SIGNI	Charlett							
	00. 20 1333									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float heart. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	EMILY	W.		Taylo	OR	OUTOBER &	24, 1995	2140 "
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		IPLACE (State or Foreign
	217-48-8519	1 🗆 M 2 🔀 F	93 YRS.	MONTHS DAYS	HOURS MIN.	June 13, 190		w Laware
_	Se. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN O	R LOCATION OF D	EATH	9c. COUNTY OF D	
DIRECTOR	PENINSULA REGIO	NAL MEDICAL	CENTER	S	ALISBURY	<u>. </u>	WICOM1	CO
D D	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland Wico	mico		Salisbur	У			LIMITS?
A A	10e. STREET AND NUMBER	***			ZIP CODE		10g. CITIZEN OF V	
ER.	110 Cloverdale S	t.			21801		USA	
FUNERAL		12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DECI	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No — 14. RACE	— American Indien,
ВУ	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 KNO Speci			
	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S U			T	Whit	e
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Give kind of wo	vrk done during mos	n it of working	16b. KIND OF BUS	SINESS/INDUSTRY	
P	12	College (1-4 or 5+)	Owner/o	perator		Conveni	ence Stor	·e
O	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden		
BE C	Emil We	nzel			Christ	ine	Faske	
5	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street ar	nd Number or Rural	Route Number, City or Town	n, State, Zip Code)	
-	Jeanette T. Brown		30392	Mallard	l Dr., D	elmar, MD	21875	
	20e. METHOD OF DISPOSITION 1 ── Burlai 2 □ Cremation 3 □ Remov	ral from State 20b.F	PLACE AND DATE OF	DISPOSITION (Net	ne of		CATION — City or To	wn, State
	4 Donation 6 Other (Specify)	Wi	comico Mem	orial Par			alisbury,	MD
1	I I I I I I I I I I I I I I I I I I I	71///			oway Fu	neral Home		
\Box	JH211.K	Clour		501	Snow Hi	11 Rd., Sa	lisbury,M	D 21801
ш	23. PART I. Enter the diseases, or co shock, or heart failure. Li	mplications that caused	the death. Do no	t enter the mod	ie of dyling, suc	ch as cerdiac or respi	ratory arrest,	Approximats interval Between
1 4	IMMEDIATE CAUSE (Final				. 1	_		Onset and Death
	disease or condition resulting in death) a.	DECOMPENSA	TED CONC	CONGESTIVE HEART FAILURE				
		4	CONSEQUENCE OF)					
CERTIFICATION	Sequentially list conditions, b.	DUE TO (OR AS A C	STEN CONSEQUENCE OF:					240945
B	If sny, lesding to immediate cause. Enter UNDERLYING							
Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF):					
E	resulting in death) LAST							
AL C	PART II. Other significant conditions	contributing to death but	t not resulting in	the underlying	cause given in	Part I. 24s. WAS AN	AUTOPSY 24b.	WERE AUTOPSY FINDINGS
					51.	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE
MEDIC						1 _ YES 2	□ NO	OF DEATH?
2	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAI	N []		1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	20	8. PLACE OF DEATH					
Sic		HOSPITAL:		OTHER:	5 🗆 Reeldence	6 Other (Specify)		
E	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJUI	OF 28c, INJU	IRY AT	28d. DESCRIBE HOW IN	JURY OCCURED	
BY	1 Netural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO			
0	3 Suicida 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Specify	- At home, farm, str	eet, factory, offica		28f. LOCATION (Street a City or Town, State)	nd Number or Rural R	oute Number,
H								
AP.	29e. CERTIFIER (Check only one)	AN: To the best of my knowled	dge, death occurred	at the time, data	and place, end due	to the ceuse(e) end man	ner as stated.	
COMPLETE	2 MEDICAL EXAMINER:	On the beels of examination a	and/or investigation,	In my opinion, da	ath occured at the	time, date end place, end	dua to the cause(e)	end menner ee stated,
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI		29d. DATE SIGNED	(Month, Day, Year)
10	Cylinge Character of Delegation				MD 44	061	Ocrosi	× 25, 1995
	30. NAME AND ADDRESS OF PERSON WHO	4)	, , , , , , , , , , , , , , , , , , , ,		C 11			
		(MD) 540 F	RIVER SIDE	DRIVE	Suite 4	SALISBU	lry mo	ग्रहर।
	31. DATE FILED (MONTH), Day, Year) 0CT 26 1995	32. REGISTRAT'S SIGNAT	or Kardall					
البسا		11/						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	it permit Pan	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.		
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vithin 24 h	pletely filled	remation.	ent, the	
executed v	and com	o burial, c	natic evi	
ificate be	physician	ene prior t	her trau	
death cert	e attending	ental Hygi	iry, or of	
s that the	ned by th	alth and M	any inju	
aw require	s been sig	ept. of Hea	3 shows	
JAN: The	rtificate ha	ne State D	or item	
NG PHYSIC	ter this ce	ath with th	marked,	
ATTENDI	LECTOR: A!	rs after de	n 28 is	
SPITAL DR	VERAL DIR	nin 72 hou	VT: If ite,	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TA hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUI	be filed with	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		IT OF HEALTH AN	D MENTA	L HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE	E OF OEATH	3. TIME OF OEATH	_
	Robert	Clayto	^ -	TORR Sc	MONT		995 1705	M
		S. SEX 6. ASE (In yrs. las	st birthday) IF UND	ER 1 YEAR IF UNDER 24 HR	s. 7. DATE	OF BIRTH	8. BIRTHPLACE (State or Foreign	-
	229-18-2640	12 M 2 D F 74	YRS. MONTHS	DAYS HOURS MIN		th. Day. Year)	Country)	
	9a. FACILITY NAME (If not institution, give stree	it and number)	9b, CI	TY, TOWN OR LOCATION OF			UNTY OF DEATH	\dashv
OR	PENINSULA REGION	AL MEDICAL CEN	TER	SALISBUR	Y		ICOMICO	
5	RESIDENCE OF DECEDENT							
DIRECTOR	10a. STATE 10b. COUNTY	omack	10c. CITY, TOWN	4 1 4 2 11 11			10d. INSIDE CITY LIMITS?	
			VV	atts vill	<		1 TYES 2 NO	
RAI	100. STREET AND NUMBER 116 Tul	0		101. ZIP CODE		10g. CIT	TIZEN OF WHAT COUNTRY?	
FUNERAL				230	483		U. S.A.	
	1 Never Married 2 M Married	2. WAS DECEOENT EVER IN U.S. AR FORCES? 1 X YES 2 1	RMED 13	WAS DECENDENT OF HIS If yes, specify Cuban, Ma	xican, Puerto	N? (Specify Yes or No— Rican, etc.)	14. RACE — American Indian, Black, Whita, alc.	
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TES 2 NO Sp	ecity:		Specify:	
O	15. DECEDENT'S EDUCAT	TION 16a, DE	CECENT'S USUAL	OCCUPATION	168	b. KIND OF BUSINESS/IN	HOUSTRY	-
COMPLETED	(Specify only highest grade cor Elementary/Secondary (0-12)		live kind of work done Do NOT use retired.	during most of working				
P	8	- A	my Co	The of Endly	1000	Civil.	Service	
ő	17. FATHER'S NAME (First, Middle, Last)		1	18. MOTHER'S	NAME (First,	Middle, Maiden Surname)		╡
BE 0	Daniel J.	imes Tarr	Sr	Be	rtie	Blovom		
TO B	19a. INFORMANT'S NAME (Type/Print)	19	b. MAILING ADDRES	SS (Street and Number or Ru	iral Route Num		ip Code)	Η
F	Jusie Tar	C	7116 7	ull Cr. W	attsv	ville Va	23483	-
	20a. METHOD OF DISPOSITION 1 M Burial 2 □ Cremation 3 □ Remove		AND DATE OF DISPO		DAT	E 20c. LOCATION -	- City or Town, Stata	П
	4 Donation 5 Other (Specify)	Controllery, Cre	OWNIA	y Ceneter	19/2	1/1 Oak H	all Va.	ı
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE OO OO	2 0 32	NAME AND ADDRESS OF	FACILITY	6327 CK	urch ST	
	Gonstance of	alger Good L	Develoy S	alyer Funt	el Hone	Ch . t.	eur Va 23936	-
	23. PART i. Enter the diseases, or com	plicatione that ceused the de	eath Do not ente	r the mode of dying, s	such as can	diec or reepiratory at	rrest, Approximate	٦
	iMMEDIATE CAUSE (Fine)	t only one ceuse on each line	B.				Interval Between	
	disease or condition resulting in death) a. (ongestive Hegat Fairure							
	DUE TO (OR AS A CONSEQUENCE OF):							
Z	Sequentially list conditions, 6 b. Curry on the sequence of th							
Ĕ	oue to (or as a consequence of): if any, leading to immediata cause. Enter UNDERLYING							
5	CAUSE (Disease or Injury	DUE TO (OR AS A CONSEC	OUENCE OF					4
CERTIFICATION	that initiated events resulting in deeth) LAST	DUE TO (ON AS A CONSEC	DOENCE OF):					ı
E	d							4
A	PART II. Other significent conditions of	ontributing to death but not r	resulting in the u	ndarlying cause given	In Part I.	24s. WAS AN AUTOPSY		П
PHYSICIAN: MEDICA						1 Tes 2 No	AMILABLE PRIOR TO COMPLETION OF CAUSE	1
MEI						_ ~	OF DEATH?	-1
ä	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF DEA	TH YES	NO UNCERTA	AIN Ø			-
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	E OF DEATH (Check					╛
YSI	1 TYES 2 NO 1	Inpatient 2 ER/Outpatient 3	DOA 4 Nu	Ft: Irsing Home 5 ☐ Rasiden	ce 6 🗆 Othe	or (Specify)		
H	27. MANNER OF CEATH 1 Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d, OE5	SCRIBE HOW INJURY OC	CURED	٦
BY	2 Accident Investigation		M	1 YES 2 NO				
	3 Suicida 8 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY — At hor building, atc. (Specify)	ma, farm, street, fac	rtory, offica	28f. LOC City	ATION (Street and Number or Town, State)	r or Rural Route Number,	
COMPLETED								╛
릴		N: To the best of my knowledge, de-						1
Š	2 MEDICAL EXAMINER: C	On the beals of examination and/or i	Investigation, in my	opinion, death occured at	the Ilme, data	and place, and due to the	he cause(a) and menner as stated.	1
BE 0	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE	NUMBER	29d. DAT	TE SIGNED (Month, Day, Year)	
0	July			D34	168	•	10/25/95	
-	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH (ITEM	M 27) (Type, Print)				11 10	\exists
	DY. JEFFREY NIEL	AND M.D.	560 KIV	ERSIDE OR.	B101	1 SALISBU	14, MD 21801	
	31. OATE FILEI) (Month, Day, Year)	32. REGISTRAR'S SIGNATURE						7
	OCT 26 1995	Julia Davidson Ras	blalk					1

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requ TO THE FUNERAL DIRECTOR; After this certificate has been

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an.	ransit permit. P	
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attending physicis	5 should be detached for use as the b	
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it 24 hours after death. Page 6 may be retained by the hospital or at	funeral	
ifter (v the), or removal,
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN	E	0.00
		1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH MONTH DA	W YE	3. TIME OF DEATH
		MARVIN	MERRILL		TIN	GLE	octobera		
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. 8	SIRTHPLACE (State or Foreign Country)
2		214-36-6095 9a. FACILITY NAME (If not institution, give		58 YRS.			July 16, 1937		Maryland
DINOUS C	E	PENINSULA REGI	·			ALISBURY	EATH	9c. COUNTY O	
1, 5,	СТС	RESIDENCE OF DECEDENT		OLIVILIA		IBIODUNI			
, ages 1,	DIRECTOR	10a. STATE 10b. COUNT		7.5	TOWN DR LOCAT	ION			10d. INSIDE CITY LIMITS?
	1	Maryland Wi	comico	H.	ebron				1 X YES 2 NO
5	RA	105 E. Church S	t.		101	21830		USA	OF WHAT COUNTRY?
80	FUNERAL	11. MARITAL STATUS	12. WAS OECEDENT EVER II		13. WAS DEC	ENDENT OF HISPAN	IIC DRIGIN? (Specify Yes	or No 14.	RACE — American Indien,
	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, spe		n, Puerto Rican, etc.)	Tredical I	Black, White, etc. Specify:
3								W.	Thite
3	TED	15. DECEDENT'S EDI (Specify only highest grad	le completed)	(Give kind of wo life. Do NOT use	ork done during mo.	IN st of working	Pump Ma		
	PL	Elementary/Secondary (0-12)	College (1-4 or 5+)	Laborer	,		(Dresser		
ouce.	COMPLET	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden		,
75	BE C	Franklin Otis Ti	ngle			Edith	Anna Down	nes	
notified	2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town		
9		Gwen E. Willough					Salisbury		
must		1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State cem	netery, crematory or oth	er place)		1.0	CATION — City	
ner n		21. SIGNATURE OF SUMERAL SERVICE L		oringhill Me		DENS D ADDRESS OF FAC		bron,	MD
examiner		DIVE	1/00	1-		-	neral Home		
removal.	_	23. PART I. Enter the diseases, or	complications that cause	the death Do no	501	Snow Hil	ll Rd., Sal	lisbury	
or remova medical		snock, or neart failure.	List only one cause on a	ach line.	Carriar Gia IIIO	aa or dying, soci	is a cardiac or respir	atory arrest,	Approximate interval Between
the the		IMMEDIATE CAUSE (Final disease or condition	metanto	Stage R	1 And	admi	o comme	1000 at	Onset and Death
f, cremation, event, the		resulting in death)	DUE TO (OR AS A	CONSEDUENCE OF)	ov woc	0000000	0 00000000	7776	a weeks
	Z	Sequantially list conditions,	b						
Hygiene prior to buna or other traumatic	ATI	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (DR AS A	CONSEDUENCE OF):					
her t	임	CAUSE (Disease or injury that initiated events	c. OUE TO (DR AS A	CONSEDUENCE OF):					
Or o	CERTIFICATION	resulting in death) LAST	d,						
injury,		PART II. Other algorificant condition	na contributing to death b	ut not resulting in	the underlying	Cause given in	Part i. 24s. WAS AN	AUTOBEV T	24b. WERE AUTOPSY FINDINGS
amy in	ICAL			at the total and the	and underlying	Cause given in	PERFOR	MED?	AMILABLE PRIOR TO COMPLETION DF CAUSE
shows a	IEDIC,						1 TYES 2	NO	OF OEATH?
of of	N.	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO N	UNCERTAIN	-		1 TES 2 NO
hours after death with the State Dept. of Health and Item 28 is marked, or item 23 shows any in	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH					
he Sta	YSI	1 TES 2 NO	Inpetiant 2 ER/Outp		OTHER: Nursing Home	5 - Residenca (6 Other (Specify)		
with t	PHY	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY WO	RK?	28d, DESCRIBE HOW IN	JURY OCCURE	D
marked	è l	2 Accident Investigation	28e. PLACE OF INJURY	- At home form et-		ES 2 ND			
after d		3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Spec	cify)	eet, factory, offica		28f. LOCATION (Street a City or Town, State)	nd Number or Ru	iral Route Number,
hours	9	290. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the beat of my knowl	lados, dosth accumud	at the time date	and along and disc			
2 4	COMPL		ER: On the basis of examination						use(a) and manner as stated.
be filed within 7	В	29b. SIGNATURE AND TITLE OF APPTIFIE		^		29c. LICENSE NUM			NEO (Month, Day, Year)
MPO MPO	0	Mer	VENDED YYY			0208	507	> /m/	23/95
	5	30. NAME AND ADDRESS DE PERSON	O COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, P	rint)	01 0	-		
}		702-CDH 41, B	TRASTO 11		ARRILL	74 7V	LISBURY	- MAT	21801
, [31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE P			-		
6		OCT 25 1995	Have dimensi	readall					

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found read of the retained by the highest provided by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
TRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGI			
	1. DECEDENT'S HAME (First, Middle, Last)	NANCY		1 Au	AYLOR LOR	2. DATE OF DEATH	DAY	995 024/A	
	4. SOCIAL SECURITY NUMBER 214-52-0490	1 🗆 M 2 💢F	(In yrs. last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Marth, Day, Year July 6,	1949	BIRTHPLACE (State or Foreign Country) Maryland	
TOR	98. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 96. COUNTY OF DEATH WICOMIC								
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Pittsville						10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 34077 Old Oce	an City Road		101.	ZIP CODE 21850			IN OF WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 NO	13. WAS DECE If yee, spe 1 YES	cify Cuban, Maxica	NIC ORIGIN? (Specify in, Puerto Ricen, etc.) y:	Yea or No — 1	4. RACE — American Indian, Black, Whita, atc. Specify: White	
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mos	t of working		BUSINESS/INDU	STRY	
E COMPLET	17. FATHER'S NAME (First, Middle, Last) Bert A. Ward				18. MOTHER'S NA	ME (First, Middle, Mail	den Sumame)		
10 B	19a. INFORMANT'S NAME (Type/Print) Eleanor G. Ward (mother)				Aoute Number, City or - Crisfie		ode) 21817	
TO BE CON	20s. METHOD OF DISPOSITION 1 M Burles 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of ognoticy, cremetory or other place) Sunnyridge Memorial Park 11/6/95 Crisfield, MD								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817								
ERTIFICATION	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdisc or reepiratory street, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition recuiting in death) Approximate interval Between Onset and Death Approximate interval Between Onset and Death								
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): ATTIS DUE TO (OR AS A CONSEQUENCE OF): ATTIS ATTI								
: MEDICAL	PERFORMED? 1 YES 2 PAO OF						24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
IAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAII	V 🗆		1 123 2 110	
PHYSICIAN:	1 Nes 2 No	HOSPITAL:		OTHER:	5 Residence	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	(Month, Day, Year)	28b. TIME INJU	RY WOR		28d. DESCRIBE HO	W INJURY OCCU	RED	
	2 Accident investigation 3 Suicide 5 Could not be datermined 26e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 26e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								
COMPLETED		ICIAN: To the best of my know						couse(s) and manner as stated.	
TO BE CO	296. SIGNATURE AND TITLE OF CERTIFIE	M. Cum	110		29c. LICENSE NUI	MBER		SIGNED (Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON WH	As INCOME A	0 0		100 E.	Carroll S	t Sa	21801 disbury, MD	
	11. DATE FILLED (Month), Day, Vent) Hules	A MARCHANTANA	DHE						

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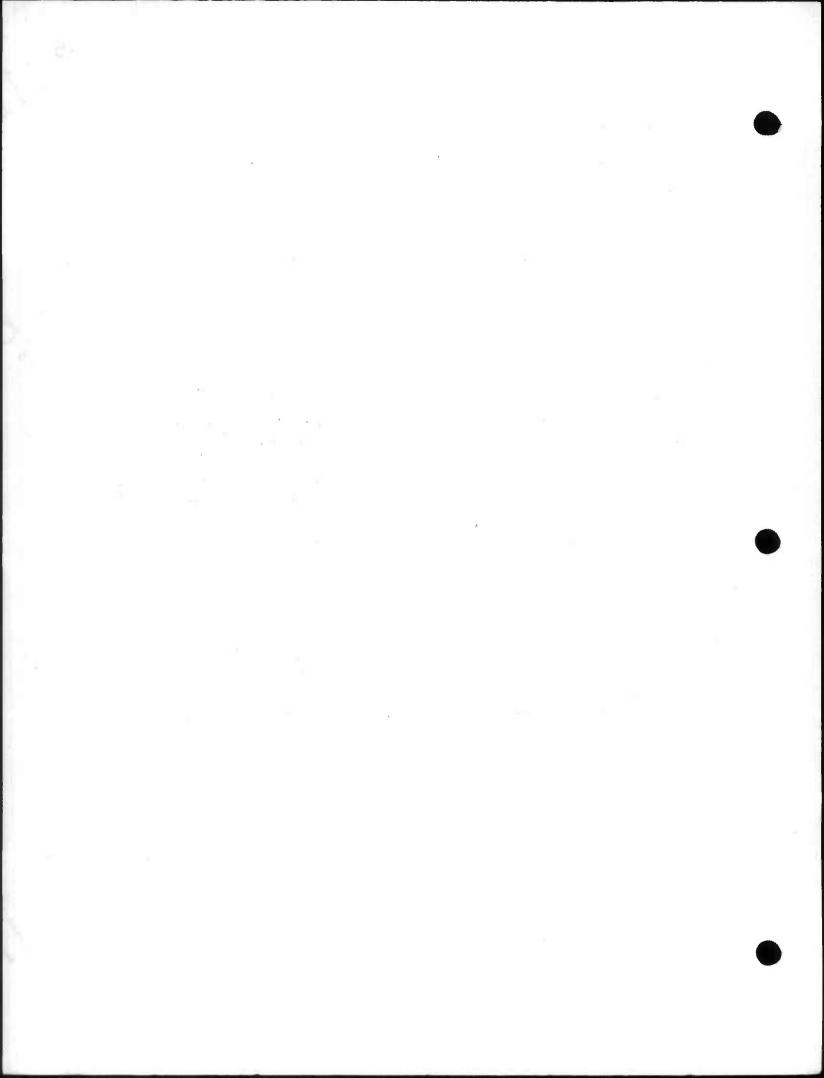
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withinours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	in	lely filled in by the	nation, or removal.	I, the medical e
	ate be executed with	ysician and complet	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	traumatic even
î	the death certifica	/ the attending ph	d Mental Hygiene	Injury, or other
	law requires that	as been signed by	Dept. of Health an	23 shows any
	3 PHYSICIAN: The	er this certificate h	th with the State (arked, or Item
	AL OR ATTENDING	AL DIRECTOR: After	2 hours after deal	If Item 28 Is m
	TO THE HOSPIT.	TO THE FUNERA	be filed within ?	IMPORTANT

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH 3. TIME OF DEATH									
100 100	Helen Cecelia Trien	<u>11</u>		October 31 1995 8/								
8		E (In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR	(Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)							
	298-40-2268 1□ M 2 □X	97 YRS.		09/25/18	98 Ohio							
Œ	96. FACILITY NAME (If not institution, give street and number) Westminster Nursing Home		9b. CITY, TOWN OR LOCATION OF Westminste		9c. COUNTY OF DEATH Carroll							
DIRECTOR	RESIDENCE OF DECEDENT		WCBUMINBU		Carrorr							
REC	10e. STATE 10b. COUNTY		Y, TOWN OR LOCATION		10d, INSIDE CITY LIMITS?							
	Maryland Carroll 10a. STREET AND NUMBER	We	stminster	1 TYES 2 NO								
FUNERAL	1234 Washington Rd.		21157	10f, ZIP CODE 10g. CITIZEN OF WHAT United								
J.	11. MARITAL STATUS 12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED	13. WAS DECENDENT OF HIS If yes, specify Cuben, Ma		a or Ne- 14. RACE — American Indian, Black, White, atc.							
ВУ	1 Never Married 2 Married FORCES? 1 YE S GIVE WAR OR		1 TYES 2 NO Sp		Specify: White							
	15. DECEDENT'S EDUCATION	16e. DECEOENT'S	USUAL OCCUPATION	16b, KIND OF BU	SINESS/INOUSTRY							
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of v	vork done during most of working e retired.)									
MPI	12	housev	rife									
CO	17. FATHER'S NAME (First, Middle, Last)			NAME (First, Middle, Maiden								
BE	John Willman		Mary									
10	Jeanne P. Hurley		ADDRESS (Street and Number or Ru Bishop Court									
	178 politic X Cremention 3 Removal from State	emetery, cremetory or of	per place)	SPOSITION (Name \$1/3/95 OATE 20c. LOCATION — City or Town, State place)								
	4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LICENSEE	calvary	Cemetery 22. NAME AND ADDRESS OF		arwater, Florida							
	Pritts Funeral Home & Chapel											
	X atherine Protts - Swee	FLC	412 Washi	ngton Rd.	, Westminster, MD							
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heert feliure. Liet only one cause on aach lina. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Due 10 (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEDERNCE OF): DUE TO (OR AS A CONSEDERNCE OF):											
ERI	resulting In deeth) LAST											
EDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?											
Σ	DID TOBACCO USE CONTRIBUTE TO	CALICE O	E DEATH VEC CO	1	1 TYES 2 NO							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	CAUSE O		NO 🗆								
S	EXAMINEN? 1 YES 2 NO 1 Inputant 2 ER/O	durilles a Cl Box	OTHER:									
H	27. MANNER OF DEATH 28s. DATE OF INJUR	7 28b, TIM	E OF 28c. INJURY AT	28d. DESCRIBE HOW I	NJURY OCCURED							
ВУ Р	1 Natural 5 Pending (Month, Day, Year 2 Accident Investigation	INJ	WORK? M 1 YES 2 NO	1200000	THOUSE OCCUPED							
8	3 Suicide 8 Could not be 4 Homicide determined	281. LOCATION (Street and City or Town, State)	and Number or Rural Route Number,									
	29a. CERTIFIER	uuladaa daab aaa										
COMPLET	(Check only 1 CERTIFYING PHYSICIAN: To the best of my knoone) 2 MEDICAL EXAMINER: On the basis of examinate											
BE	296. SIGNATURE AND TITLE OF CERTIFIER	NUMBER	29d. DATE SIGNED (Month, Day, Year)									
5	30. NAME AND EDDRESS OF PERSON WHO COMPLETED CAUSE OF I	DEATH (ITEM 27) (Type,		0611	Istamati							
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SK	ENATURE	1-0-BUX	x 71 00	124 aluals							
	NOV 1 1995 Julia David											



or attending physician. r use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 2	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the filed within 72 hours after death with the State Dent of Health and Mental Horiene nors to build cremation or removal	gd
YLAP	by the h	be detac	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Ë, N	ay be re	page 5	be no
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Ę	eath. Pa	uneral	camine
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XO	be exe	ician ar	Irauma
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.	quires t	n signer	OWS a
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	1 - STATE STATE OF MARYLAN	ID / DEPART	MENT OF HEALTH AND I	MENTAL HYGIEN	E						
	REGISTRAR	CERTIFIC	CATE OF DEATH	REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH MONTH DA	AY YEA	3. TIME OF DEATH							
	DELPHIN EDWARD TRIEBER			OCTOBER 2		20:20 P M					
			IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. B	IRTHPLACE (State or Foreign					
	219-03-8630 ¹ √x ^{M 2 □} F 87	YRS.	MONTHS DAYS HOURS MIN.	APRIL 8 1908 Marvland							
	9a. FACILITY NAME (If not institution, give street and number)	1	9b. CITY, TOWN OR LOCATION OF DE		9c. COUNTY C						
1 8	MEMORIAL HOSPITAL		CUMBERLAND		ALLEG	* A 1\T\7					
5	RESIDENCE OF DECEDENT				LALILEG						
DIRECTOR		10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY LIMITS?					
	MARYLAND ALLEGANY	CUMI	BERLAND			1 X YES 2 NO					
MA M	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN (OF WHAT COUNTRY?					
	1824 FREDERICK STREET		21502		U.S						
FUNERAL	11. MARITAL STATUS 1 Never Merried 2XX Merried 12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2	S. ARMED	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Maxica		or No- 14. F	RACE — American Indian, Black, White, etc.					
BY	1 Never Merried 2XXXMerried FORCES? 1 YES 3 3 Widowed 4 Divorced	XX	1 YES 2 NO Specify			Spec#WHITE					
ETED	(Specify only highest grade completed)	(Give kind of wo life. Do NOT use	USUAL OCCUPATION Ork done during most of working	16b. KIND OF BUS	SINESS/INDUSTR	KY .					
1 #	Elementery/Secondary (0-12) Collega (1-4 or 5+)										
COMPL	12+ 4 E	LECTRICA	AL ENGINEER			ELD TIRE CO.					
			18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)						
	EDWARD EDWIN TRIEBER	T		SOYSTER							
TO BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING A	AOORESS (Street and Number or Rural I	Route Number, City or Town	n, State, Zip Code	ı)					
	MARY-RETA TRIEBER 1824 FREDERICK STREET CUMBERLAND MARYLAND 21502										
HIE	1 Suriel 2 Cremation 3 Ramoval from Stata cemeter	ry, crematory or other			CATION — City o	r Town, State					
	4 Donation 5 Other (Specify) ROS		CEMETERY NOV 1 1		BERLAND	MARYLAND					
examine	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND A ODRESS OF FAI		03477						
CAd	Dale I. Herrell		MERRITT-ADAMS 404 DECATUR ST								
	23. PART I. Enter the disessee, or complications that caused the	ne desth. Do no	ot enter the mode of dying, such	h es cerdiec or respi	ratory srrest,	Approximate					
	shock, or heert failure. Liet only one ceuse on each IMMEDIATE CAUSE (Finel	ı ilns.	- 70			intervsi Betwesn Onset and Dasth					
	disease or condition Motochotic	Feanhac	geal Carcinoma			3 Months					
É	resulting in desth) s. MELASTALIC					5 FIOREIS					
		,	,								
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	INSEQUENCE OF):				<u> </u>					
N N	couse. Enter UNDERLYING	0.377				İ					
三三	CAUSE (Diseese or injury that initiated events OUE TO (OR AS A CO	ONSEQUENCE OF):									
	resulting in deeth) LAST										
5 -											
SICAL	PART ii. Other significent conditions contributing to deeth but	not resulting in	the underlying cause given in	Pert I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINGINGS AVAILABLE PRIOR TO					
MEDICAL				1 _ YES 2	X NO	COMPLETION OF CAUSE OF OEATH?					
W						1 WES 2 NO					
	_ DID TOBACCO USE CONTRIBUTE TO CAUSE OF I	DEATH YES	NO W UNCERTAIN	N 🗆							
N S		PLACE OF DEATH									
S	EXAMINER? t ☐ YES 2 NO HOSPITAL: 1 ☐ Inpetient 2 XER/Outpetle		OTHER: 4 Nursing Home 5 Residence	6 Other (Specify)							
PHYSICIAN:	27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJURY AT	26d. DESCRIBE HOW IN	NJURY OCCURE	D					
BY F	1 Nstural 5 Pending 2 Accident Investigation	INJUR	M 1 YES 2 NO								
2 0	3 Suicide 28s. PLACE OF INJURY —	At home, farm, atri	reel, factory, office	261. LOCATION (Street e	and Number or Ru	iral Route Number,					
	4 Homicide determined building, etc. (Specify)			City or Town, State)							
	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge	a doub commed	led the three data and allows and dur-								
COMPLETE	(Check only one) 2 MEDICAL EXAMINER: On the beels of examination an					unde) and manner or stated					
8											
	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUM	IBER		NED (Month, Day, Year)					
2	71747		033280		Oct	30, 1995					
	30. NAME AND ACCRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, P	rint)								

CUMBERLAND MARYLAND

21502

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

DR SUNTL K.
31. OATE FILED (Morth, Day, Year)
OCT 3 1 1995

FOR

. DECEDENT'S NAME (First, Middle, L		mayr on	TD		2. DATE OF OEATH MONTH	°25 1995	3. TIME OF DEATH 12:30 P M
ROY	AHTO	TAYLOR	JR.	A 1	OCTOBER		
. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birtho	MONTHS DAY		JUNE 10	8.8	HRTHPLACE (State or Foreign country)
214-30-9735	1 X M 2 🗆 F	61 YR					IEST VA
a. FACILITY NAME (If not institution,				VN OR LOCATION OF D	DEATH	9c. COUNTY	
SACRED HEART		-	COMB	ERLAND		ALLE	GANY
Da. STATE 10b. CO		10c.	CITY, TOWN OR LO	CATION			10d. INSIDE CITY
MARYLAND A	LLEGANY		CUMBER	LAND			LIMITS?
De. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
15503 WINSL'0	W STREET	S.W.		21502		U.	S.A.
1. MARITAL STATUS		NT EVER IN U.S. ARMED			NIC ORIGIN? (Specify	/ee or No- 14.	RACE — American Indian,
Never Merried 2 X Married	FORCES? IF YES, GIVE	WAR OR DATES		s, specify Cuben, Mexic YES 2 X NO Speci			Black, White, etc. Specify: WHITE
Widowed 4 Divorced	1953	-1974		and the second			WIIIIL
15. DECEDENT'S 'Specify only highest		(Give kind	NT'S USUAL OCCUP d of work done during	PATION g most of working	16b. KIND OF E	USINESS/INDUST	RY
Elementary/Secondery (0-12)	College (1-4 or 5	+)	Sgt./C1	ark	Air Fo	orce /	Railroad
12		Tech.	390.701				Natiti ou u
7. FATHER'S NAME (First, Middle, Las					AME (First, Middle, Maid BELLE JO		
9e. INFORMANT'S NAME (Type/Print)	Lon, on				Plante Number, City or 1		
	AYLOR	155			S.WCUI		
200. METHOD OF DISPOSITION	AILUK		ATEOF DISPOSITION		The second second second	LOCATION — City	
□ Burlel 2 🂢 Cremation 3 🗆	Removal from State	anmalani aramatan	or other placel		11 1	CUMBERL	
Donation 5 Other (Specify)	CE LICENSEE	- ICOMBERI		EMATORY	1-11-1	JOHDENE	AND, NO
wh. In	0		GEO	RGE-UPCH	URCH FUN	ERAL HO	OME, P.A.
Glendy ()	, lacke	ich					MD 21502
23. PART I. Enter the diseases shock, or heart fell	, or complications thure. List only one ca	at caused the death.	Do not enter the	mode of dying, su	ch as cardiec or res	piratory erreat,	Approximate interval Between
IMMEDIATE CAUSE (Finel	1	_ (111			Onset and Deat
resulting in death)	o. L 1	VER (10 H			7 days
	DUE TO	O (OR AS A CONSEQUEN	CE OF):	10	Live		
Sequentielly list conditions,	Lan	cery (-DW	1 With	n eche	1	37 Lay
If any, leading to immediate cause. Enter UNDERLYING	DUE TO	OH AS A CONSEQUENT	IV a	10/21	12		
CAUSE (Disease or Injury	c. OUE TO	OR AS A CONSEQUENCE	CE OFI:	vitus			
that initiated events resulting in death) LAST			,-				
	d						
PART il. Other significant cond	ditions contributing t	o deeth but not reault	ting in the under	lying ceuse given in		AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
- du	abete	s oue	2 (0	1 cars		2 2 NO	COMPLETION OF CAUSE OF DEATH?
							1 TYES 2 NO
DID TOBACCO USE CO	INTRIBUTE TO C	AUSE OF DEATH	YES NO	W UNCERTA	IN 🗆		
25. WAS CASE REFERRED TO MEDIC EXAMINER?		26. PLACE OF	DEATH (Check only	one)			
1 TYES 2 NO	HOSPITAL:	☐ ER/Outpatient 3 ☐ De	OA 4 Nursing	Home 5 - Reeldence	8 Other (Specify)		
27. MANNER OF DEATH	28e. DATE C (Month,	F INJURY 28b	TIME OF 280	INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCUR	ED
1 Natural 5 Pending 2 Accident Investigs			M 1	YES 2 NO			
3 Suicide 8 Could no	ot be building	OF INJURY — At home, fr g, atc. (Specify)	arm, street, factory,	office	281. LOCATION (Stre City or Town, Str	et end Number or F ite)	Rural Route Number,
4 Homicide determin	90						
Check only	PHYSICIAN: To the beat	of my knowledge, death o	ccurred at the time,	date end pleca, and du	us to the cause(s) and i	manner ae stated.	
	AMINER: On the basis of	axemination and/or invest	tigation, in my opini	on, death occured at th	ne time, data end place,	end due to the ce	ouse(e) end menner ee stated.
296. SIGNATURE AND THE OF CER	runen, / //			29c. LICENSE N	UMBER	29d. DATE SI	GNED (Month, Day, Year)
000 u	Mota	QUIIA	2	0-1-	7526		OBER 30-199
30. NAME AND ADDRESS OF PERSO	N WHO COMPLETED CA	USE OF DEATH (ITEM DAT	Thing Print)	2	2 /		11-
John Mehr	nna M.D	901-B	Seton	Drive (umport	and,/	40 2150=
11. DATE FILED (Month, Day, Year)		IAN'S SIGNATURE	10111	11100	-11-11-11		1000
OCT 3 0 1995	Japa Dave	Gor Rardall					

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BOX	
S, P.O.	
RECORDS,	
L REC	
OF VITAL F	
ONO	
DIVISION	

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

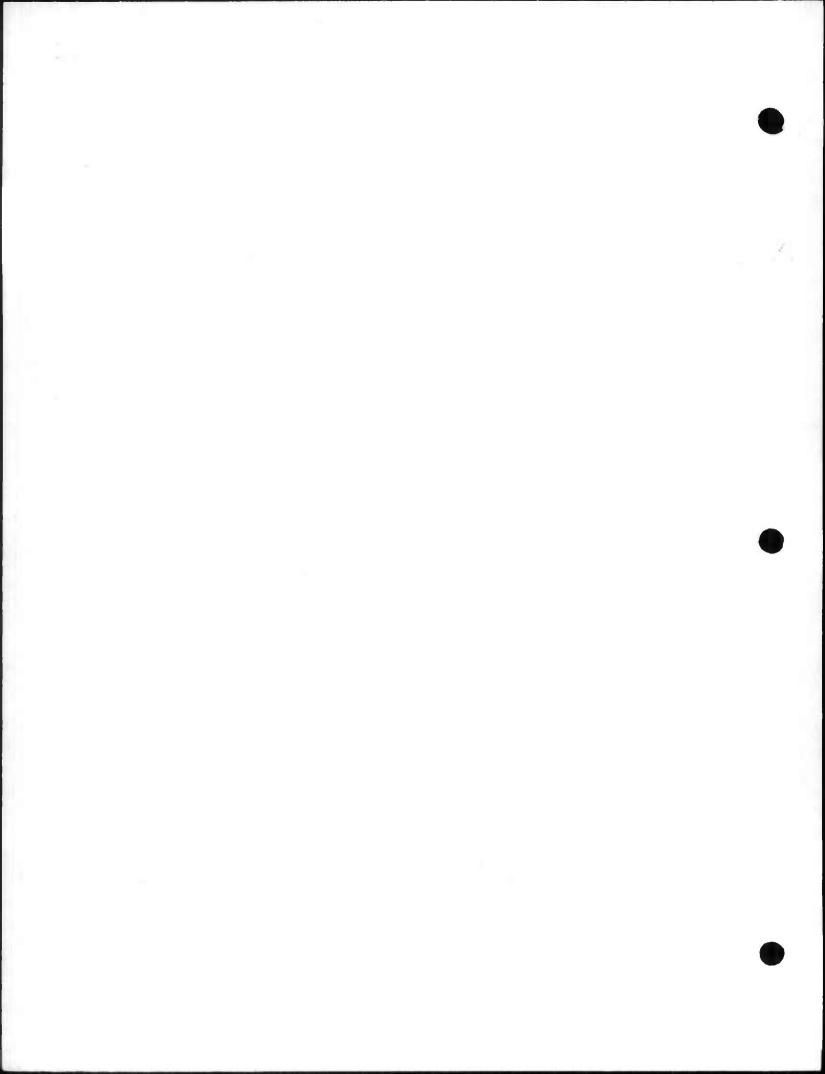
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1 - STATE REGISTRAR	STATE UF M					DEATH DEATH			GIEN G. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH												3. TIME OF DEATH
	GLADYS LILY TRITAPOE OCTOBER 26 1995											6:30 P M	
	4. SOCIAL SECURITY NUMBER	8. AGE (In yrs. la:	(In yrs. last birthday) IF UNDER 1			IF UNDER 24 H	IRS. 7				8. BIRTH	IPLACE (State or Foreign	
	212-38-8668	1 ☐ M 2 🔀 F	92	YRS.	MONTHS	BYAG	HOURS MI	IIN.	OCT. 1		1903	VII	RGINIA
	9e. FACILITY NAME (If not institution, give stre		-	9b. CITY,	TOWN 0	R LOCATION C			- ,		NTY OF D		
OR	1638 ROHRERSVILL	E ROAD				I	(NOXVI)	LLE				WASI	HINGTON
בל	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY			100 017	Y, TOWN OF		1041						
DIRECTOR		WASHINGT	ONT	100. 011	v, rown or			.					10d. INSIDE CITY LIMITS?
1	10e. STREET AND NUMBER	WASHINGI	OIV_				OXVIILE 1. ZIP CODE				I to- CIT	IZEN OF V	1 YES 2 X NO
RA	1638 ROHRERSVILL	E BOYD				""		50			10g. CI1	U.S.	
FUNERAL		12. WAS DECEDENT	EVER IN U.S. AF	U.S. ARMED 13. WAS DECEMBENT OF HISPANI					ORIGIN? (Son	cify Yes	or No-		E — American Indien.
BY FI	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WA	YES 2 X	2 X NO If yes, specify C			cify Cuben, M	lexican, i				Speci	k, White, etc.
	15, DECEDENT'S EDUCA	ATION	18e. DE	CEDENT'S	USUAL OC	CUPATIO	N		16b. KIND	OF BU	INFSS/INI	VIITELL	WHITE
	(Specify only highest grade of Elementary/Secondary (0-12)		(6		work done du				Too. Killy	01 80.	JINE 33/1141	7031H1	
P	8	College (I-4 br 5+)	'	Н	OMEMA	KER					OWN	HOME	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		-					S NAME	(First, Middle,	Maiden	Surname)		
BE C	ROBERT LEE WATERS	5					ANNIE	RE	BECCA	JOY	NKIN	S	
TO B	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	nd Number or R	Rural Rou	rte Number, City	or Tow	n, State, Zij	Code)	
F	ROBERT M. TRITAPO	E		1638	ROHRE	ERSV	ILLE F	ROAD	, KNO	(VII	LE,	MD	21758
	20e. METNOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Remov	ral from State	20b. PLACE			FION (Na	ne of		DATE	20c. LO	CATION —	City or To	wn, State
	4 Donetion 5 Dother (Specify)		OLD	BRÓWI	NSVIL					BRO	WNSV.	LLE,	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICH	1//			1,000,000		D ADDRESS O	1. 1. 10015	7	606	014	Nati	onal Pike
	\$660 1 (NOO)	John John	n H. Ba	st Ji	BA:	ST E	UNERA	L HO	JMF:				
	23. PART i. Enter the diseases, or compilections that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory errest, shock, or heart fellure. List only one cause on each line. Approximate interval Between												
	iMMEDIATE CAUSE (Finei	st only one ceus	se on eech line	ð.									Interval Between Oneet and Death
	disease or condition resulting in deeth)		Re	Respiratory Friture							her min		
- 1	resulting in death,	DUE TO (
Z	Sequentielly list conditions, b. Premaria												
CERTIFICATION	if any, leeding to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A CONSE	QUENCE O	F):								
은	CAUSE (Diseese or injury C.	DUE TO (OR AS A CONSE	OUENCE O	ICE OF):								
ĒΙ	that initieted events resulting in death) LAST				,								i
	- d.												1
CAL	PART ii. Other significent conditione									MAS AN	AUTOPSY MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
음	Anterio relevatio	Cardina	Marley	DU	rear		Alria		_ 10	YES 2	9 NO		COMPLETION OF CAUSE OF DEATH?
MED	E brillation												1 _ YES 2 _ NO
ä	DID TOBACCO USE CONTRI	BUTE TO CAL	JSE OF DEA	TH YE	S N	10 🗆	UNCERT	TAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	OTHER:								
YSI	1 TYES 2 NO	1 Inpatient 2		□ DOA			5 - Heside	nce 8	Other (Spec	ify)			
PH	27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF II (Month, Day	INJURY y, Year)	28b. TIM	E OF	28c. INJU WOI	RK7		Sd. DEŞCRIBE	NOW I	NJURY OC	CURED	
B	2 Accident Investigation				М.	1 🗌 Y		\rightarrow					
	3 Suicide S Could not be 4 Nomicide determined	28e. PLACE OF building, e	INJURY — At he atc. (Specify)	me, farm,	atreet, factor	ry, office		2	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
9	29e. CERTIFIER												
COMPLETED	(Check only one) 1 CERTIFYING PNYSICI. MEDICAL EXAMINER:												Value and a second seco
8		On the basis of ex	imination englor	investigatio	n, in my op	inion, de	eath occured a	it the tin	ne, date end p	lace, en	d due to ti	te Ceuse(e	end manner ee stated.
B	29b, SIGNATURE AND TITLE OF CERTIFIER	att mo					29c. LICENSE		R				(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO		E OF DEATH AT-	M 27) (5	(Infant)		D (8	264	_		-0	~ · · · · ·	12,195
	VASANT DATA		334 ~			KA	S FR S	704	مم لمد	w -	, ,	(43	
					•					ر	-('	~ 0	
	UCI 5 0 1995 July	REGISTRAR	re-to-4										

T. . 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAN				CERTI	ICATE	Ur	DEAL	П		REG. NO.			
S .		1. DECEDENT'S NAME (First,				2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH								3. TIME OF DEATH	
,		James Ch	October 21, 1995							2:33 A M					
	1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest bit 19					IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH 8. BIRTHPLACE (State			PLACE (State or Foreign
100		213-90-962	YRS.	MONTHS	MONTHS DAYS HOURS MIN. (Month, Day, Year)						Dela				
should		9a. FACILITY NAME (If not institution, give street and number)						rown	OR LOCATIO	ON OF DE		, 10 10		INTY OF D	
60	Œ	Rt 272 & 1	R+ 124	6					East	J. O. D.					EAITI
1, 2,	CTOR	RESIDENCE OF DEC		NOL	LII	East				Cec	:11				
Sec	H.	10a. STATE	10b. COUNT	7		10c. CI	TY, TOWN OF	LOCA	TION					T	10d. INSIDE CITY
2	5	MD	Cec	il		R	sing	Sur	n				LIMITS?		
permit. Pages 1,	7	10e. STREET AND NUMBER		8	_	of, ZIP CODE				1 ☐ YES 2 ▓ NO 10g. CITIZEN OF WHAT COUNTRY?					
155	FUNERAL	1051 Calve		- 1	21911				USA						
physician. burial-transit	N N	11. MARITAL STATUS	or or ita	12. WAS DECEDEN	T EVED IN I	I C ADMED	1 40 94	_		e 11100411					
ohysi		1 Never Married 2 Married FORCES? 1 YES 2 No IF YES, GIVE WAR OR DATES					NO If yes, specify Cuben, Maxican, Puerto Rican, etc.)							14. RACE Black	— American Indian, , White, atc.
as the	B	3 Widowed 4 Divo	rced	IF YES, GIVE Y	WAR OR DAT	ES	1	YES	S 2 (₹NO			Specifi			
ttend e as	8	15. DEC	EDENT'S EDU	CATION	11	6a. DECEDENT'S	USUAL OCC	LIPATI	ION		185	. KIND OF BUS	INESC /INI		
or a	E	(Specify onl) Elementary/Secondary (0	highest grade	completed) College (1-4 or 5		(Give kind of life. Do NOT of	work done du	ring me	ost of working	g	100	TOTAL OF BOX	HIVE 337 HIVE	DOSTRI	
spital ed fe	4	12	Carpe	ntor					Consta						
e hos	COMPL	17. FATHER'S NAME (First, MI	Carpe	nter		10 140774	EDIC MAI		Constr Widdle, Meiden		on				
o d to		Warren Und							omery	Sumama)					
par par	띪	19a. INFORMANT'S NAME (7)	ma (Drint)												
retained by the hospital or att 5 should be detached for use notified at once.	임	Tom & Wanda		11an		1051	Calva	Street i	DA D-	or Aurel A	oute Numi	ber, City or Town	7, State, Zip	o Code)	
ay be				- Luii				_		LSIII					
hours after death. Page 6 may be retained by the hospital or attending physician, ed in by the funeral director, page 5 should be detached for use as the burial-tran or removal. medical examiner must be notified at once.		20e. METHOD OF DISPOSITION 1 X Burlat 2 Cremation 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION /Name of cemetery, crematory or other place)													
age 6 direct		4 □ Donation 5 □ Other (Specify) West Nottingham Cemetery 10-25-95 Colora MD													
death. Pag tuneral di I. examiner		21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY R. T. Foard Funeral Home, PA													
after death. Page 6 m by the funeral director. smoval. Ilcal examiner must		R. T. Foard Funeral Home, PA 111 S Queen St Rising Sun MD 21911													
d in by the or removal.		23 PAST I Frier the diseases or completions that exceed the death Past 111 5 Queen St. RISTING Sun Fill 21911													
hours or re	1 1	snock, or neert failure. List only one ceuse on each line.													
y fille		IMMEDIATE CAUSE (Finel disease or condition													
within pletely cremal		disease or condition a. Multiple Injuries Due to (or As A consequence of): Due to (or As A consequence of):													
ed within complete al. crema event,				DUE TO	(OR AS A C	ONSEQUENCE	ዋ):								
ate be executed within 24 hor ysician and completely filled prior to burial, cremation, or traumatic event, the m	No I	Sequentially list conditions, DUF TO (OR AS A CONSEQUENCE OF).													
be e	CATION	If any, leading to immediate couse. Enter UNDERLYING													
vires that the death certificate be execute signed by the attending physician and c Heatth and Mental Hygiene prior to buria ws any Injury, or other traumatic	일	CAUSE (Disease or Injury \$ a.													
Jing Yoler Oth	ERTIFIC	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
ath cath	빙	d													
that the dea led by the ati th and Menta any Injury,		PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS													
d by and	EDICAL		PI						PERFORMED? AVAILABI		AVAILABLE PRIOR TO				
signe signe Health WS a	8	1 🗆 YES 2 NO COMPLETION OF CAUSE OF DEATH?													
	Σ	1 TES 2 NO													
law Dept	AN	25. WAS CASE REFERRED TO		KIBUIE IO CA] UNC	RTAIN	1 🗆				
OR ATTENDING PHYSICIAN: The law requires that the DIRECTOR: After this certificate has been signed by the hours after death with the State Dept, of Health and Mitem 28 is marked, or flem 23 shows any inju	PHYSICIAN:	EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF DEA	OTHER:	ly one)							
CIAN ertific the S	ı X	1 N YES 2 NO		1 Inpetfent 2			4 - Nursin	g Hom	ne 5 🗆 Res	ildence (8 Other		uton		R
NDING PHYSI R: After this circ death with its marked,	표	27. MANNER OF DEATH 1 Netural 5 F	ending	28a. DATE OF (Month, D		26b. TIN	IE OF 2		JURY AT DRK?	,	28d. DES	CRIBE HOW IN	JURY OC	CURED	
WG P	BY		nveatigation	16/21	95	213	3.AM	1 🔲 '	YES 2	NO	Pusse	nay -1	futo	acci	Lent
R: Al	0		could not be	28e, PLACE O	F INJURY — atc. (Specify)	At home, farm,	street, factor	y, offic	Roude	ray	26f. LOCA	ATION (Street a	nd Number	or Rural Ro	oute Number,
OR ATTENDING DIRECTOR: Atter hours after death item 28 is ma	ETE	4 Homicide	letermined	KTZ	12 ne		1/6	2000	nun t	CN	10-12		ne	2 Rt	274
DIRECTOR A	MPLE	29e. CERTIFIER (Check only	FYING PHYSIC	CIAN: To the best of	my knowled	ge, death occur	ed at the tim	e. dete	and place	and due t	to the cau	ned and men	nor on olei	ad a	
TO THE HOSPITAL, TO THE FUNERAL BE filed within 72 I IMPORTANT: If I	Ĭ N														and manner as stated,
TO THE HOSPI TO THE FUNER DE filed within	8	29b. SIGNATURE AND TITLE													
오 일본 보	8	YII	1 A						29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	Month, Day, Year)
263 🚡	2	20 NAME AND ADDRESS	Mus,	11)					1//	5 >	14		- 0	90%	er 21, 1995
	- 1	30. NAME AND ADDRESS OF	1	COMPLETED CAUS	SE OF DEAT	H (ITEM 27) (Type	, Print)		4						
		111, far	Kas,	~ 'Y,	mio	m Hos	C., E	1 / k	Jon,	m	0 2	1921			
			bar)	32. REGISTRA		URE									
)		OCT 24 199	13 YW	his d'hucles	rada	14									
			1												



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CERTIF		OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)		1.		20011	2. DATE OF DEATH MONTH DA	AY	YEAR	3. TIME OF DEATH
	2/5/8	Embrey	U.	,	RBACK	OCTOBER		995	0610 AM
	4. SOCIAL SECURITY NUMBER 5. S 578-10-9796 1	(In yrs. last birthday) 97 YRS.	MONTHS DA	AR IF UNDER 24 HRS. YS HOURS MIN.	(44-44 0-14-4		8. BIRTHPLACE (State or Fore Country) Virginia		
~	9e. FACILITY NAME (If not inatitution, give atreet as				WN OR LOCATION OF DI	EATH	9c. COUN		
TO	Shady Grove Adventi	st Hospita	al	Rock	ville		Mont	tgome	ery
DIRECTOR	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR L	OCATION				10d. INSIDE CITY LIMITS?
	Maryland Montgome	ery	Gai	thersb	ourg				1 YES 2 NO
FUNERAL	301 Russell Avenue,	# 416A			101. ZIP CODE 20877			JSA	HAT COUNTRY?
S		MAS DECEDENT EVER				NIC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indian, White, etc.
BY		FORCES? 1 TYES F YES, GIVE WAR OR I			s, specify Cuben, Mexics YES 2 X NO Specif			Specify	
ED	15. DECEDENT'S EDUCATION (Specify only highest grade complete)	N leted)	18e. DECEDENT'S	USUAL OCCU	PATION ag most of working	16b. KIND OF BUS	SINESS/INDU	JSTRY	
COMPLETED	Elementary/Secondary (0-12) Col	lege (1-4 or 5+)	life. Do NOT u	rse retired.)		77			.,
MP	17. FATNER'S NAME (First, Middle, Last)	0	Waitr	ess/As	sistant		L Coff	tee S	Shop
	James W. Embrey					ME (First, Middle, Meiden Cooper	Sumeme)		
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St		Route Number, City or Tow	n. State. Zin	Gode)	20877
2	Elsie M. Fransler I	Fansler				6-A, Gaith			
	20e. METNOD OF DISPOSITION 1	20	b. PLACE AND DATE	OF DISPOSITIO	N (Neme of		CATION — C		
	4 Donation 9 Gher (Specify)	F	ort Linc			10/30 Bre			
	21. SIGNATURE OF ETHERAL SERVICE LICENSE	+-4h	Oh. d	7 118	300 New Han	mpshire Ave	enue		uneral Home
	21 PART I. Enter the diseasea, or comp	licetions that course	d the death Do			g, Maryland			Approximete
	shock, or heart fallura. List of	only one cause on	each ilna.		, thous or dying, add	or resp	natory arre	zmr,	Interval Between
	IMMEDIATE CAUSE (Final disease or condition								
	reaulting in death) s,	DUE TO (OR AS	CONSEQUENCE)F):	CAR! 0)	100/2			7 /1100/3
z	A thrunschunder Hourt Dismos WERDS								
OIT)	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	OF):					
CERTIFICATION	CAUSE (Disease or Injury c. DUE TO (OB AS A CONSEQUENCE OF):								
RTI	that Initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST								
CE	d								
MEDICAL	PART II. Other algnificant conditions con	-	1		. /	Part i. 24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
200	Congi	5941'UE	HEMMY	111	1000	1 YES 2	NO		COMPLETION OF CAUSE OF DEATN?
M									1 TYES 2 NO
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
ICI'	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1	SPITAL:		OTHER:					
PHYSICIAN:	27. MANNER OF DEATN	Inpatient 2 - ER/Out	28b. TII		Nome 5 Residence	8 United (Specify) 28d. DESCRIBE NOW I	INJURY OCC	HRED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN	JURY M 1	WORK?				
COMPLETED	3 Suicide 8 Could not be 4 Nomicide determined	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, term, street, factory, office building, attc. //Specify att. of Pure Street and Number or Rural Route Number, building, attc. //Specify Dura Street							
PLE	29e. CERTIFIER (Check only	To the best of my kno-	wledge, death occur	red at the time,	, date end place, end due	to the ceuse(e) end me	nner es atate	ed.	
W C	one) 2 MEDICAL EXAMINER: On	the beele of exeminati	on end/or investigati	on, in my opini	on, death occured at the	time, date end piece, er	nd due to the	e ceuse(s)	end menner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	- /	1		29c. LICENSE NU	MBER	29d. DATE	SIGNED	(Month, Day, Year)
TO BE	30. NAME AND ADDRESS OF PERSON WHO CO	ONE OF DE	DAL MI	D Print)	017	947	10	ctor	pen 27, 1993
	GARY W. LAND	4570N	MID	790	1 Medic	cal Cepta	Par.	Ros	Shortle Mel
	31. DATE FILES (Month, Dey, Veer) OCT 31 1995	32. BEGISTRAR'S SIG	NATURES Nardall						20850
		-							

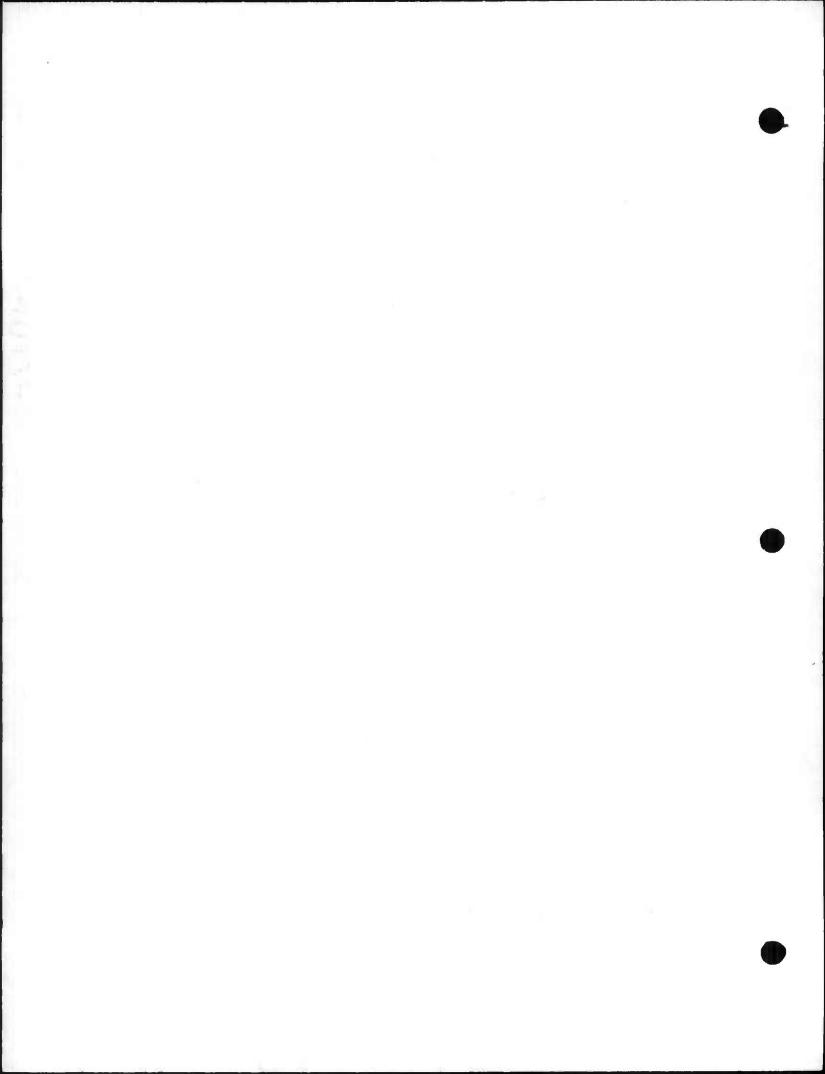
9 · . = •

& BALTIMORE, MARYLAND 21215-0020	Page 6 may be retained by the hospital or attending physician.	
BAL	flar death	
X	Nours a	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executions by the hospital or attending physician.	

31. DATE FILED (Month, Dev. Year) 1995

32 AEGISTAAR'S SIGNATURS Julia d'Auxlion Randall

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEF CERT	ARTMENT (OF DEATH	MENTAL HYGIE REG. N			
	1. DECEDENT'S NAME (First, Middle, Last)	Etta Virgi	ie Van	Dyke		2. DATE OF DEATH MONTH October	17, 1995	3. TIME OF DEATH	N
	4. SOCIAL SECURITY NUMBER 216-18-4418 9a. FACILITY NAME (If not institution, give s	1 🗆 M 2 📉 F	(In yrs. last birtho	S. MONTHS D	AYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 18,	1901 Vi	RTHPLACE (State or Foreign unity) .rginia	
CTOR	Calvert Manor Nu				ing Sun	DEATH	Sc. COUNTY OF	F DEATH	
DIRE	Maryland Ceci			North Ea				10d. INSIDE CITY LIMITS? 1 YES 2 NO	_
FUNERAL	240 Trinity Chur	ch Road			10f. ZIP CODE 21901		U.S.A	F WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yo	B DECENDENT OF HISPA is, specify Cuban, Mexic. YES 2 NO Speci	an, Puerto Rican, atc.)	Bi	ACE — American Indian, lack, Whita, atc.	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind life. Do NO	IT'S USUAL OCCU of work done durin of use retired.)	PATION ng most of working	166. KIND OF B	USINESS/INDUSTRY	1	
BE COM	17. FATHER'S NAME (First, Middle, Last) William R	leedy			18. MOTHER'S NA	Nancy Dy			
TO	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nell Delp 240 Trinity Church Road - North East, MD 21901								
	20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cempetery, crematory or other place) Union Cemetery 100 ATE 1 20c. LOCATION — City or Town, State Union, Maryland								_
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, MD 21921								
	23. PART I. Enter the diseases, or a shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. DUE TO (OR AS	each line.	o not enter the	mode of dying, suc	ch as cerdiac or res	piratory errest,	Approximate interval Betwee Onset and Dea	
RTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated awards. OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):							zay	1
CERTI	that initiated events resulting in death) LAST		nede					254	_
MEDICAL	PART II. Other significent condition	s contributing to deeth t	but not reculti	ng in the under	lying cause given in	Part I. 24a. WAS A PERFO	DRMED?	4b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	S
ICIAN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LA UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)								
₹ I	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Out		OTMER:	Home 5 - Residence	6 Other (Specify)			_
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b.	INJURY	Rec. INJURY AT WORK? 1 YES 2 NO				
ETED I	3 Suicide 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY building, atc. (Spe	Y — At home, far cify)	m, atreet, factory,	office	28t, LOCATION (Stree City or Town, Stat	t and Number or Rure e)	al Route Number,	
MP		CIAN: To the best of my know R: On the besis of exemination						e(s) and manner as stated.	
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIEF				29c. LICENSE NUI	MBER	29d. DATE SIGNI	ED (Month, Day, Year)	
0	30. NAME AND ADDRESS OF PERSON WHO		EATH (ITEM 27)	ype, Print)	D0482	3	10/2	20/95	_



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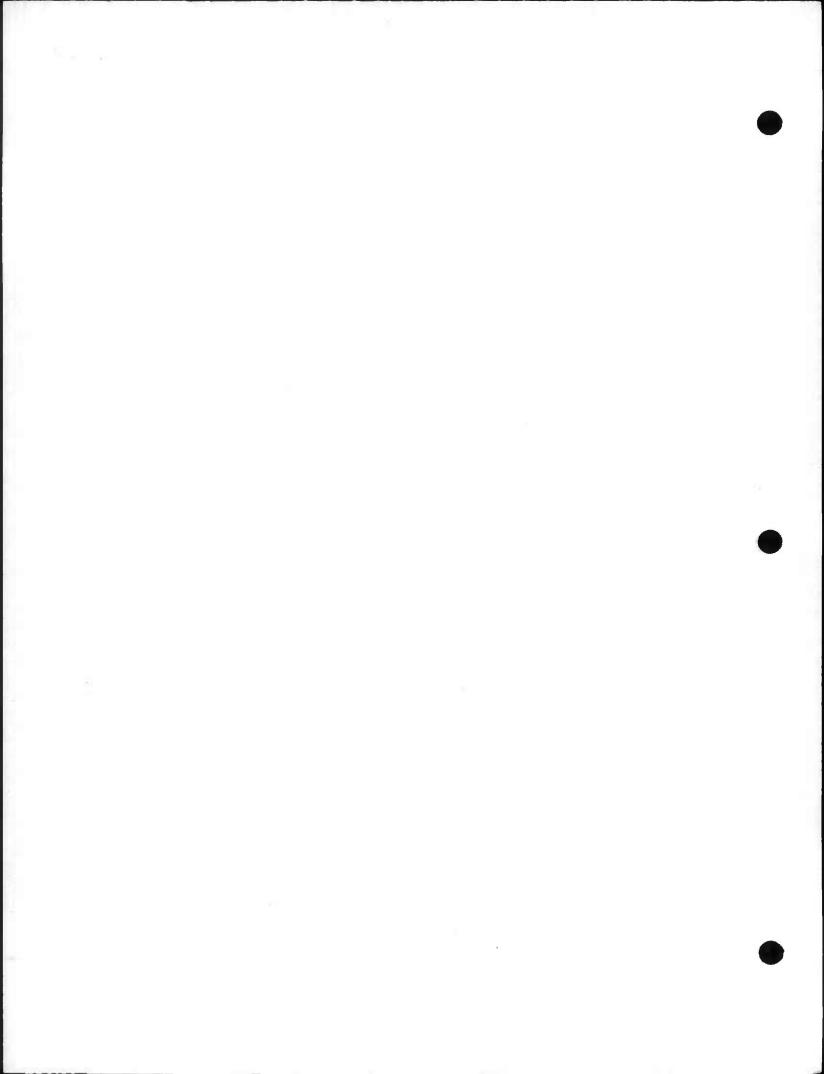
DIVISION OF VITAL

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. The hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

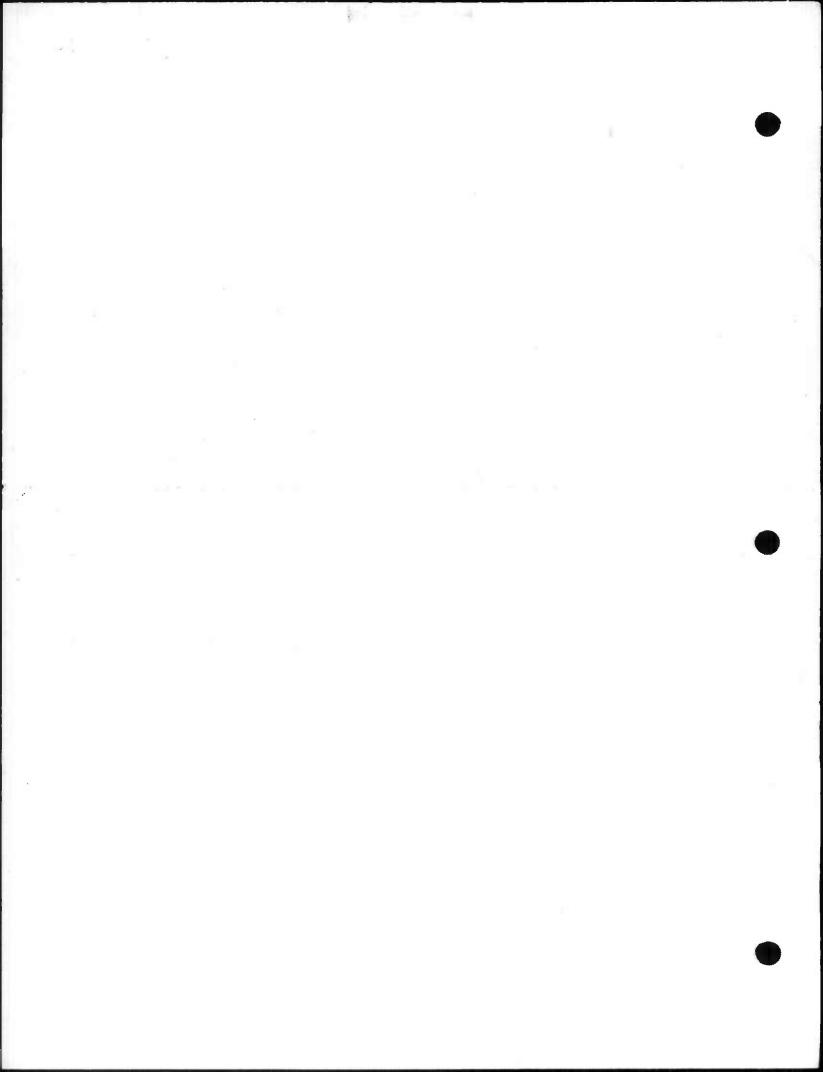
IMPORTANT: It them 28 is marked, or them 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPART CERTIFIC	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	3. TIME OF DEATH			
	Jacob W. Van Den Heuvel, Jr.		October 18	1,1995 8:34 P M			
		IF UNDER 1 YEAR IF UNDER 24 HRS,	(Month, Day, Year) Country)				
	219-44-8967 1XJ M 2 L F 29 YRS.			19∯6 De.			
Œ	9a. FACILITY NAME (If not institution, give street and number) 670 Fe11 Road	9b. CITY, TOWN OR LOCATION OF D					
DIRECTOR	RESIDENCE OF DECEDENT	Rising Sun		Cecil			
REC		TOWN OR LOCATION		10d. INSIDE CITY			
		ising Sun		1 ☐ YES 2 🔀 NO			
RAI	10. STREET AND NUMBER 670 Fell Road	101. ZIP CODE		0g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	219		U.S.A.			
	1 Never Married 2 Married FORCES? 1 YES 2 NO	13. WAS DECENDENT OF NISPA If yes, specify Cuben, Mexico	an, Puerto Rican, etc.)	Black, Whita, atc.			
BY	3 Wildowed 4 Divorced	1 TYES 2 X NO Specif	у:	Specify White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of wo	rk done during most of working	16b. KIND OF BUSINE	ESS/INDUSTRY			
ZE.	Elementary/Secondary (0-12) College (1-4 or 5 +) into Do NOT use Truck		Tranco	ortation			
N N	17. FATNER'S NAME (First, Middle, Lust)		ME (First, Middle, Malden Sun	ortation			
U C	Jacob W. Van Den Heuvel, Sr.		Atkinson				
00		DDRESS (Street and Number or Rural					
5	Marvin A. Van Den Heuvel 240 St	tar Route Rd.	, Elkton,	Md. 21921			
	20a. METNOO OF DISPOSITION 1 □ Burlal 2 ☑ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF Cemelary, crematory or other	DISPOSITION (Name of		ION — City or Town, Stata			
	4 Donation 5 Other (Specify) R. A. Fer	ris & Co.,	West	Chester, Pa.			
	21. BIONATURE OF PUNEMAE SERVICE UCENSEE	22. NAME AND ADDRESS OF FA		E. Main St.,			
	JAPXI XLL	Gee runeral	. Home Elk	ton, Md. 21921			
- 1	23. PART I. Enter the diseases, or complications that ceused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, suc	th as cardiec or respirate	ory errest, Approximate interval Between			
- 1	IMMEDIATE CAUSE (Final disease or condition	6060 00 1	,)	Onset and Death			
	disease or condition resulting in death) s	MILLE mall Cel		3 mo			
2							
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate OUE TO (OR AS A CONSEQUENCE OF):						
2	cause. Enter UNDERLYING CAUSE (Disease or injury						
Ë l	that initiated svents DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST						
Ë	d						
AL	PART II. Other significant conditions contributing to death but not resulting in	the underlying ceuse given in	Part I. 24s. WAS AN AUT				
9			· 1 □ YES 2	COMPLETION OF OTHER			
M			Ac	1 TES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL	DEATH YES NO					
Sic	EXAMINER? / HOSPITAL:	OTHER:					
H	27. MANNER OF DEATH 28s. DATE OF INJURY 26b. TIME	OF 28c. INJURY AT	28d. DESCRIBE NOW INJU	IRY OCCUREO			
ВУР	1 Netural 5 Pending (Month, Day, Year) INJUI 2 Accident Investigation	M 1 YES 2 NO					
	3 Suicide 6 Could not be 28a. PLACE OF INJURY — At home, farm, str building, atc. (Specify)	set, factory, offica	281. LOCATION (Street and City or Town, State)	Number or Rural Route Number,			
COMPLETED							
AP.	29a. CERTIFIER (Check only one) PNYSICIAN: To the best of my knowledge, death occurred						
00	2 MEDICAL EXAMINER: On the basis of axamination and/or investigation	in my opinion, death occured at the	fime, data and place, and de	us to the cause(s) and manner as stated.			
BE	296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NU		od. OATE SIGNEO (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, F	D15314	+	October 19, 1995			
	Dr. Henry Farkas Northern Chesapeake H	777 239 S.	Bridge Stre	et			
	31. OATE Ell EQ (Month Day Year) 22 DEGISTRAD'S SIGNATURE	mahice ETKCOU	, PID CIGCI				
	OCT 20 1995 July Duvidson Randall						



FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR			CEHI	IFICA	IF O	DEA	TH_		REG. NO).		
		1. DECEDENT'S NAME (First, Middle, La Iva Myrtle W	right							MONTH		AY 1.0	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX	6 AGE (In	yrs. last birth	de di estant	DER 1 YEAR				ber 2	1 19		0512 м
				o. AGE (III	73 YF	MONTH			MIN.	(Month,	Day, Year)		Country	
should		219 - 58 - 4928 9a. FACILITY NAME (If not institution, gi		L	73 1	10.00					1 20,			ginia
3 Sh	Œ					90. C		OR LOCATION	ON OF DE	EATH		9c. COUN	ITY OF DE	
1, 2,	СТОВ	Union Hospital	of Cecil C	Joun t	У		E.	lkton					Cec	<u>il</u>
Pages	III I	10a, STATE 10b. COU	INTY		10c	. CITY, TOW	N OR LOC	ATION						10d. INSIDE CITY
. 	DIR	Maryland	Cecil				E11	cton						LIMITS? 1 YES 2 NO
permit.	ERAL	10e. STREET AND NUMBER					1	lof. ZIP CODI	E			10g. CITIZ	EN OF WI	HAT COUNTRY?
isi .	🖺	44 St. Michael'	s Court						2	1921		Un	ited	States
UZU physician. burial-transit	FUNI	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1			1					(Specify Yes	or No-	14. RACE	- American Indian, White, atc.
	ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE V			- 1		specify Cuba S 2 🔀 NO			ican, atc.)		Spec//	7 77 0 .
or attending r use as the	ED	15. DECEDENT'S E	OUCATION		44- 000000	1								
F 5 .		(Specify only highest gr	rade completed)		(Give kin-	d of work do OT use retired	ne during n	TION most of workin	10	16b.	KIND OF BU	SINESS/INO	USTRY	
2 E P	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	•)	Homen						Low.	own H	020	
AND he hospit detached	NO.	17. FATHER'S NAME (First, Middle, Last)			Homen	laicel		18 MOTE	HED'S NA	ME /Eint M	IIEI (Ollie	
3 & A		Beecher Sexton						2007		Stro		Surrame)		
MAHYL. retained by the 5 should be of notified at a	BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAI	LING ADDRI	ESS (Street				er, City or Tow	n. State. Zin	Code1	
	٩	Shirley Asbury			1						7, E1			21922
HE, nay be t page		20a. METHOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremation 3 ☐ R			PLACE AND D	ATE OF DISP	OSITION (,	DATE	_	CATION —		
ALLIMORE Jeath, Page 6 may funeral director, pa		4 Donation 6 Other (Specify)		- No	rth Ea	or other place	ethod	list C	lem.	10/2	4 No	rth F	ast.	Maryland
	1 1	21. SIGNATURE OF PUNERAL SERVICE	LICENSEE	/		lè	2. NAME	AND ADDRES	SS OF FA	CILITY	<u> </u>	I CII I	ubeş	Haryrand
		11/AL99	4/200	X								North	Faci	t, MD 21901
ins after on by the removal.	\vdash	23. PART I. Enter the diseases, I	or complications that	t caused	the deeth. I									
filled in by the on, or remove the medical		snock, or neart fellul	re. List only one ceu	ise DN ead	ch line.				,		oo or respi	natory arre	,	Approximate interval Between
8 € 5		iMMEDIATE CAUSE (Fine) disease or condition		7	hice	0	4. 7	of an						Onset and Death
ted with		resulting in death)	W1		CONSEQUENC		10							-
B 0 - 5	_	_	- Acute 1				reti	On						=
4 8 " O F	ERTIFICATION	Sequentially list conditions, if any, leading to immediate			CONSEQUENC		ICLI	OH						1
icate be physician to prior to er traur	8	cause. Enter UNDERLYING CAUSE (Disease or Injury	c											
		thet initiated events	DUE TO	(DR AS A C	CONSEQUENC	E OF):								
T # 8 - 0		resulting in death) LAST	d											
Me de d	L C	PART ii. Other aignificent condit	iona contributing to	deeth bu	t not reculti	ing in the	underivi	ng ceuee g	ilven in	Part I.	24a. WAS AN	AUTOPSY	24b. 1	WERE AUTOPSY FINDINGS
	EDICAL						-				PERFOR	RMED?		MAILABLE PRIOR TO COMPLETION OF CAUSE
ulres the signed Health a	D									_	1 YES 2	M NO		OF DEATH?
v req been t. of	Z: M	DID TOBACCO USE CON	NTRIBUTE TO CA	USE OF	DEATH	YES 🗆	NO F	7 UNC	FRTAIN	<u>_</u>				I PES 2 NO
he law e has t e Dept	SICIAN:	25. WAS CASE REFERRED TO MEDICAL			6. PLACE OF					•				
PHYSICIAN: The this certificate hi with the State Driked, or item	SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpet	tient 3 DC	OTH		me 6 🗆 Re	sidenca	6 Other	(Specify)			
PHYSICIA this certif with the	РНҮ	27. MANNER OF DEATH	26a. DATE OF (Month, D		26b.	TIME OF	28c. IN	JURY AT			RIBE HOW I	NJURY OCC	UREO	
NG PHYS fter this sath with	ВУ	1 Natural 5 Pending 2 Accident Investigation		ey, roer)		M		YES 2] NO					
ATTENDING P CTOR: After s after death	ED E	3 Suicide 6 Could not		F INJURY -	At home, fa	rm, street, fo	actory, offi	ica		281. LOCA	TION (Street e	and Number	or Rural Ro	ute Number,
DR ATTENDING DIRECTOR: After hours after death	ETE	4 Homicide determined								Ony or	TOWN, State)			
L DIRECT Phours	MPLE	29a. CERTIFIER 1 CERTIFYING PH	YSICIAN: To the best of	my knowle	dge, death oc	curred at the	e time, dat	ta and place,	and due	to the caus	s(a) and man	ner as atate	d.	
HOSPITAL FUNERAL Within 72 I	COM		INER: On the basis of ex											and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	BE C	290-BIGNATURE AND TITLE OF CERTIF	FIER					29c. LICE	NSE NUN	MBER		29d. DATE	SIGNED (Month, Day, Year)
F F € 2		VK &	The	•				Į.	3	3239	75	>	0.	23.45
	2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	SE OF DEAT	TH (ITEM 27) (Type, Print)							-	
		3 Mouldin	Aun	w	- Du	Lts	2	tap	$_{m}$	<u>م</u> (219	701		
		31. DATE FILED (Month, Day, Year)	32. REGISTRA	-										
		OCT 24 1995	Julia d'hurcles	ox-Rand	lall									
		(DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merial Hydiene prior to burial, cremation, or removal	
THE HOSPITAL OR ATT	THE FUNERAL DIRECTO	PORTANT: If item 28

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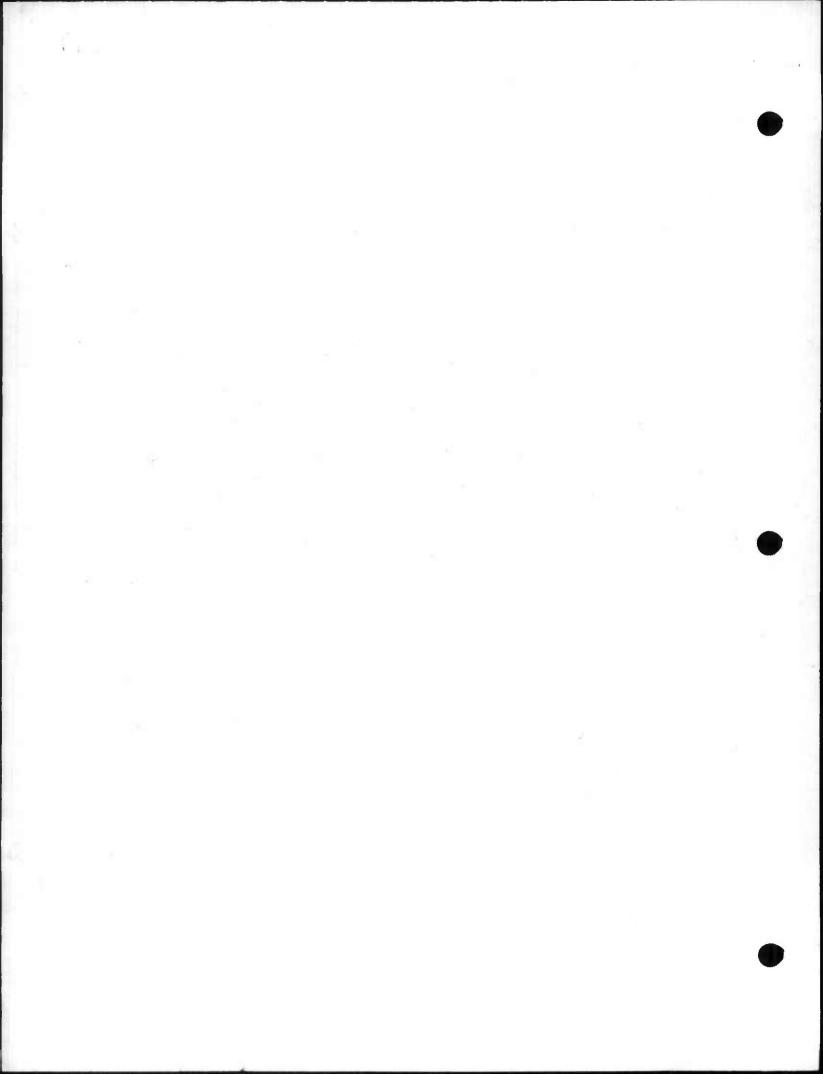
30. NAME AND ADDRESS OF PERSON

1995

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Davidson-Rondall

	3 3 . 7 U.3 . 4.1 / 1/0 P		_				95	34511
- 1	Amended #1, 11/1/95,				HEALTH AND			
	1 - STATE REGISTRAR	STATE OF MARYLA	CERTIF	ICATE OF	HEALTH AND	MENIAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)	Percy	. ,			2. DATE OF DEATH		3. TIME OF DEATH
	CYRIL PE	PRY	WAL	TON		OCT 2		YEAR 0829 M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (II	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			8. BIRTHPLACE (State or Foreign
	II/a	1 ⊠ M 2 □ F 79	YRS.	MONTHS DAYS	HOURS MIN.	July 13,1	916	Country) United Kingdom
	9e. FACILITY NAME (If not institution, give stree			9b. CITY, TOWN	OR LOCATION OF			TY OF DEATH
E	7003 Brookville Ro	oad		Chevy	Chase		Mon	tgomery
<u>[</u>	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		the CIT	Y, TOWN OR LOC	ATION			10d. INSIDE CITY
DIRECTOR	n/a Herefor	rd & Worcest			A I I I I			LIMITS?
1	10e. STREET AND NUMBER	d d worcest	er Ma	lvern	01. ZIP CODE		100 CITIZ	1 ☑ YES 2 ☐ NO EN OF WHAT COUNTRY?
ER/	10 Bolyota Port					T 37		
S		2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DI	WR 144]	L I ANIC ORIGIN? (Specify Yes		ed Kingdom 14. RACE — American Indian, Black, White, atc.
	1 Never Married 2 XMarried	FORCES? 1 YES	2 TNO	If yes, t	specify Cuben, Maxi	can, Puerto Rican, atc.)		Black, White, atc. Specify:
BY	3 Widowed 4 Divorced						1	white
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con		16a. DECEDENT'S	work done during r	TION nost of working	16b. KIND OF BU		Title of the control
LE		College (1-4 or 5+)	life. Do NOT us	,				orcester
M	12 17. FATHER'S NAME (First, Middle, Lest)	- 11	Careers	Ullice		County		11
	Percy Harry Walton					NAME (First, Middle, Malden		
B	190. INFORMANT'S NAME (Type/Print)	L	19h MARING	ADDRESS /Street	Ulive	tte Cheshir	9	2-4-1
2	Michael Walton							
	20a. METHOD DF DISPOSITION	20b.	PLACE AND DATE	OF DISPOSITION /	Te Ka.,	Chevy Chase		20815 Ity or Town, State
1 1	1 Burlei 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State ceme	tery, cremetary or a	ther place)		Oct.30.95		
	21. SIGNATURE OF PONERAL SERVICE LICEN	WE 0/0	ссторот	22. NAME	AND ADDRESS OF	FACILITY	Lexar	idria, Va.
	D (1)	120/11			1 Funera			
Н	23. PART I. Enter the diseases, or con	nolications that caused	the death. Do r	2222	Wiscons	sin Ave. N.I	V. Was	shDC 20007
	shock, or heart failure. Lia	it only one cause on as	ch lina.	TOT BINGS USE IT	ode or dynig, ac	ich as cardiac or reapi	ratory arre	interval Between
	1/	MYOCAR. DUE TO (OR AS A	DIAI	/ 1	1 FAD	cT100/		Onset and Death
1 1	resulting in death) a	1 1 0 -11/	WIIN	F):	////	01/01/		72016
1 1		DUE TO (OR AS A	CONSEQUENCE O	/ 3	/	~		
z				-10 C	PNOVAN	CULARO.D	15/5	ACT INEF
TION	Sequentially list conditions, if any, laading to immediate	DUE TO (OR AS A DUE TO (OR AS A	LEROT	70 G	RDIOVAS	CULAR D	ISEI	ASE INGF
ICATION	Sequentially list conditions,	ARTERIOS C DUE TO (OR AS A	CONSEQUENCE OF	F):	RDOVAS	CUMPR.D	ISE	ASE INEF
TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	ARTERIOSC	CONSEQUENCE OF	F):	RDIOVAS	CUMPR D	1561	ASE INEF
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	ARTERIOS C DUE TO (OR AS A	CONSEQUENCE OF	F):	RDOVAS	CUMPR.D	150	ASE INGF
O	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF	F):		n Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
O	Sequentially list conditions, if any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	F):		n Part I. 24s. WAS AN PERFOR	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DE CAUSE
O	Sequentially list conditions, if any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	F):		n Part I. 24s. WAS AN	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	F): F): In tha underlyl	ng cause given l	n Part I. 24s. WAS AN PERFOR 1 🗆 YES 2	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DE CAUSE
MEDICAL C	Sequentially list conditions, if any, isading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the condition	DUE TO (OR AS A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION OF A CONTRIBUTION O	CONSEQUENCE OF	F): In the underlyling in the u	ng cause given i	n Part I. 24s. WAS AN PERFOR 1 🗆 YES 2	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition	DUE TO (OR AS A CONTRIBUTING TO CAUSE OF	CONSEQUENCE OF DEATH YE	F): In the underlying the second of the sec	ung cause given i	n Part I. 24s. WAS AN PERFOR 1 🗆 YES 2	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
O	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition	DUE TO (OR AS A CONTRIBUTION OF TO CAUSE OF TALE)	CONSEQUENCE OF DEATH YE	F): In the underlyling the Check only one OTHER: 4 Nursing Ho E OF	ung cause given i	n Part I. 24a. WAS AN PERFOR 1 □ YES 2	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition	DUE TO (OR AS A CONTRIBUTION OF A CONTRIBUTION OF AS A CONTRIBUTION OF AS A CONTRIBUTION OF A CONTRIBUTION OF AS A	CONSEQUENCE OF CONSEQ	F): In the underlyle S NO If (Check only one OTHER: 4 Nursing Ho E OF 28c. IN WH 1	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA	n Part I. 24a. WAS AN PERFOR 1 YES 2	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
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ETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition	DUE TO (OR AS A ODUE TO	CONSEQUENCE OF CONSEQUENCE OF DEATH YES. PLACE OF DEATH INJ. At home, farm, and the consequence of the cons	F): In the underlyle S	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA NO NO NO NO NO NO NO NO NO N	Part I. 24s. WAS AN PERFOR 1 YES 2 IN 24s. WAS AN PERFOR 2 1 YES 2 Of Other (Specify) 26d. OESCRIBE HOW III 26f. LOCATION (Street a City or Yown, State)	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition	DUE TO (OR AS A CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY building, atc. (Specifical Contribution of Cause of	CONSEQUENCE OF CONSEQ	F): In the underlyle S	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA NO NO NO NO NO NO NO NO NO N	Part I. 24s. WAS AN PERFOR 1 YES 2 IN 2 Other (Specify) 26d. OESCRIBE HOW II 26f. LOCATION (Street a City or Town, State)	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition	DUE TO (OR AS A CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY building, atc. (Specifical Contribution of Cause of	CONSEQUENCE OF CONSEQ	F): In the underlyle S	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA NO NO NO NO NO NO NO NO NO N	Part I. 24s. WAS AN PERFOR 1 YES 2 IN 2 Other (Specify) 26d. OESCRIBE HOW II 26f. LOCATION (Street a City or Town, State)	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition	DUE TO (OR AS A CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF CONTRIBUTION OF TO CAUSE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY building, atc. (Specifical Contribution of Cause of	CONSEQUENCE OF CONSEQ	F): In the underlyle S	UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA UNCERTA NO NO NO NO NO NO NO NO NO N	Part I. 24s. WINS AN PERFOR 1 YES 2 IN 1 YES 2 O 6 Other (Specify) 26d. OESCRIBE HOW II 26f. LOCATION (Street end) City or Town, State) 19 to the ceuse(e) end mende lime, date end place, end	AUTOPSY MED? IN NO NURY OCCU and Number of the stated of due to the 29d. DATE:	24b. WERE AUTOPSY FINDINGS AWARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO



FOR STATE REGISTRAR

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

4	1. DECEDENT'S NAME (First,	Middle, Last)			1/1	110	0		2. DATE OF D	EATN	(10)	YEAR 3	. TIME OF	DEATN
	HERN	Somers			WAL	JKEI	<		OCTORE	e 2		795	6	OA "
	4. SOCIAL SECURITY NUMB	ER 5	. SEX 6	. AGE (In yrs. I	asl birthday)	IF UNDER 1 YE	_	IF UNDER 24 HRS.	7. DATE OF 8 (Month, Day		0		ACE (State	or Foreign
ı	577 03 490	01 1	☐ M 2 🛣 F	96	YRS.	MONTHS DA	WS.	HOURS MIH.	July 8		00	Country) Mary	land	
	9a. FACILITY NAME (If not in		t and number)			9b. CITY, TO	WN OF	LOCATION OF DE		, 10	9c. COUNT	-		
TOR	Suburban Ho					<u>-</u>	Be	thesda			Mon	tgom	ery	
<u>입</u>	10a, STATE	10b. COUNTY			10c. CITY	r. TOWN OR L	OCATE	ON				10	Od. INSIDE	CITY
DIRECTOR	Maryland	Montgo	mery			nsingt							LIMITS YES	7
A	10e. STREET AND NUMBER						101.	ZIP CODE			10g. CITIZE	N OF WH	AT COUNT	RY?
8	4417 Woodfi	eld Roa	đ					20895			Unit	ed S	tate	s
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 X Widowed 4 Divo	Married	FORCES? 1 FYES, GIVE WAI	YES 2 X		If ye	s, spe	NDENT OF NISPANI city Cuben, Maxican 2 NO Specify.	, Puerto Rican		or No— 1	4. RACE Black, \ Specify	America White, atc.	
	15. DEC	EDENT'S EDUCAT	ION			USUAL OCCU			18b. KIN	D OF BUS	INESS/INDU	STRY		
COMPLETED	(Specify only Elementary/Secondary (0	y highest grade cor	npleted) College (1-4 or 5+)		(Give kind of v life, Do NOT us	vork done durin e retired.)	ng mos	t of working	100					
7	12	F12)	college (1-4 or 5+)		Cler	k			Ins	uran	ce Co	mnan	V	
2	17. FATHER'S NAME (First, M	liddle. Last)			CICI	, ,		18, MOTHER'S NAM				mpun	1	
	John	Somers							, , , , ,			- 2 7 - 1	. 1	
BE	19a, INFORMANT'S NAME (7				10h MAII ING	ADORESS (S	reat ar	Clara od Number or Rural A	hute Number C		ot Ava		оте	
2	Edgar H. Wa							Drive,					208	52
	20s. METHOD OF DISPOSIT		denen State	20b. PLAC	E AND DATE	OF DISPOSITIO	N (Nan	ne of	OATE	20c. LOC	CATION — CI	ty or Town	n, Stata	
	4 Donation 5 Other		ii from State	Park.	lawn M			ber 30,1 Park		Rock	ville	e, Ma	aryla	and
	21. SIGNATURE OF FUNERA	L SERVICE LICEN	SEI)			22. NAI	ME AN	O ADDRESS OF FAC	Rob	ert .	A. Pu	mphr	ey F	uneral
1	1 they	1) 1	tund	M	00689			ethesda- sin Aven	_					3501
						not anter the	moc	de of dying, such	n ss cardiac	or respir	retory arre	st,		oximets
	IMMEDIATE CAUSE (Fir		ot only one ceus	e on aech ii	na.									vai Batween et and Death
	disesse or condition		Sen	Tie '	Show	ck.								
ľ	resulting in death)	8.,	DUE TO (OR AS A CONS	SEQUENCE OF	F):							+	
-			Doh	udvo	7 +18	, D/1								
ō	Sequentially list condit if any, leading to imme		DUE TO (C	AS A CONS	EOUENCE O	F):	. (-		-		
Ä	cause. Entar UNDERLY	ING	Kesn	Ira +	OVIA	Ha	1/1	ure.						
CERTIFICATION	CAUSE (Disease or injute that initiated events	ity a.	DUE TO (OR AS A CONS	SEQUENCE O	F):								
E	resulting in dasth) LAS	т	Preu	mon	1a									
CE		a.,											1	
	PART ii. Other eignifica	ent conditione	contributing to d	laeth but no	t resulting	in the unda	rlying	csuse given in	Part i. 24s	WAS AN			VERE AUTO	PSY FINDINGS PRIOR TO
MEDICAL	Necrotic	C &19	At LQ	wer	EXT	NEW	<i>u [</i>	4		YES 2	21	0		N OF CAUSE
	Atria 1	F.B	Mat	100				/			7		YES	
	DID TOBACCO U	ISE CONTRI	BUTE TO CAL	ISE OF DE	ATH Y	S II NO	ΣП	UNCERTAIN	<u>л</u> П					
A	25. WAS CASE REFERRED T					TH (Check only								
를 l	EXAMINER?	1	IOSPITAL:	EB/Outpetlant	2 🗆 004	OTHER:	. 11	S C Ocaldona	8 Other (Sc				-	
PHYSICIAN:	27. MANNER OF DEATN	;	28s. DATE OF I		28b. TIN			s 5 ☐ Residence	28d. DESCRI		NJURY OCCL	JRED		
	_	Pending	(Month, Day			JURY	WOI							
ВУ	2 Accident	Investigation	28e. PLACE OF	IN.HIBY — At	home ferm				281. LOCATIO	N /Street o	and Number o	v Rural Bo	uta Numba	,
	3 Suicide 8 3	Could not be determined		tc. (Specify)	nome, rem,	attest, lactory.	, 011100			wn, State)	707700	n riurar rioi	010 . 1011100	•
1	20 050515150 2/						_							
립	(Uneck only 7)	TIFYING PHYSICIA	AN: To the best of n	ny knowledge,	death occurr	ed at the time	, date	and place, and due	to the cause(e	and man	mer as state	d.		
COMPLETED	one) 2 MED	DICAL EXAMINER:	On the beals of axe	mination and/	or investigation	on, in my opin	ion, de	eath occured at the	time, data and	place, an	d dua to the	cause(s)	and mann	er as stated.
E	29b. SIGNATURE AND TITLE	E OF CERTIFIER						29c. LICENSE NUN	MBER		29d. DATE	SIGNED (Month, gay	(Year)
0	Merlin	Ven	unm	DP	HYSI	CIAN	7	135	791		> 1	0/2	6/	95
2	30. NAME AND ADDRESS O	F PERSON WHO	COMPLETED CAUSE	OF DEATH (, Print)		0			1 -	11-	1	2021
	M. VEMU	1-1.	801 6	EOR	614	ME		SILVER	376	RIM	V6.	MD	20	0906
	31. DATE FILED (Month, Day,			'S SIGNATURI										
	OCT 30	0 1995	Jalia Dan	where Man	dall									
			/											MMM 18 Day 1/90

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	7 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPI	TO THE FUNER	be filed within	IMPORTANT.

	1 - FOR STATE REGISTRAR	STATE OF MAI	RYLAND / DEPA CERTIF				MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) Shirley		We	einste	in		MONT	of DEATH		YEAR	3. TIME OF OEATH 2:25 A M	
		5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER	YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign	
	074-16-9431	1 🗆 M 2 💢 F	85 YRS.	MONTHS	DAYS	HOURS MIN.	Feb.	h, Day, Year)	910		w York	
TOR	5600 Wisconsin Av								Mont			
DIRECTO	10a. STATE 10b. COUNTY	acmo vii	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
	Maryland Mont	gomery		Chev	-	nase ZIP CODE			NAT COUNTRY?			
RA	5600 Wisconsin A	******* #0	0.4			20815				States		
FUNERAL		12. WAS DECEDENT E	VER IN U.S. ARMED	13. V	WAS DECI	ENDENT OF NISPAN	IIC ORIGII	N? (Specify Yes		14 BACE	- American Indian	
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, OIVE WAR	YES 2 XNO	H	yes, spe	city Cuben, Mexica 2 X NO Specify	n, Puerto			Black, Specif	, White, stc.	
G	15. DECEDENT'S EDUCA		16a. DECEDENT	'S USUAL OC	CUPATIO	N	168	. KIND OF BUS	SINESS/INDU	JSTRY	MILEC	
E	(Specify only highest grade c Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind o	f work done d use retired.)	luring mos	at of working						
COMPLETED	4	conege (1-4 or 5 +)	Exec	cutive	2		M	anufac	turin	1g &	Retail	
OM	17. FATNER'S NAME (First, Middle, Lest)					18. MOTNER'S NA	ME (First,	Middle, Maiden	Surname)			
	Alexander Diamon	nd			- 1	Rose	Roma	nov				
BE	19a, INFORMANT'S NAME (Type/Print)	i d	19b. MAILIN	O ADDRESS	(Street ar	nd Number or Rural I			n, State, Zip	Code)		
2	Beth W. Newburger		1			k Street					VA 22209	
	20a. METHOD OF DISPOSITION						-	7				
	20a. METHOD OF DISPOSITION 1 (X Burlel 2 Commettion 3 Removal from State 4 Donestion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of the commetter) commetery, crematory or other place NOVEMber 1, 1995 Temple Gates of Heaven Cemetery Schenectady, 1											
	21. SIGNATURE OF SUMERAL SERVICE LICENSEE MOO831 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/											
	Barbara Jon	k Mullen	Lawrence	e Be	ethe	sda-Chev e, Bethe	y Ch	ase, I Maryl	nc. 7	557	Wisconsin 4-3501	
	23. PART I. Enter the disagses, or for shock, or heart fellure/L iMMEDIATE CAUSE (Final disease or condition resulting in death)	Non Hode	on each line. [kin's Lym]	phoma	tha mod	da of dying, suc	h aa car	diac or respi	ratory arre	eat,	Approximata interval Batween Onaat and Daath $4\frac{1}{2}$ months	
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL (Arteriosclerotic Cardiovascular Disease								WERE AUTOPSY FINDINGS AWILLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 10 NO			
	DID TOBACCO USE CONTR	BUTE TO CAUS	SE OF DEATH	YES 🗆 N	NO [UNCERTAIL	NX					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE	ATH (Check of	only one)							
Sic	EXAMINER?	HOSPITAL:	R/Outpetient 3 🗆 DOA	OTHER	R: sing Nom	e 5 X Residence	6 Oth	er (Specify)				
НΥ	27. MANNER OF DEATN	26a. DATE OF IN	JURY 26b. T	IME OF	28c, INJ	URY AT		SCRIBE NOW I	NJURY OCC	URED		
	1 X Natural 5 Pending Investigation	(Month, Day,	Year)	NJURY M		RK? /ES 2 NO						
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicida datarmined	26s. PLACE OF II building, ato	NJURY — At home, fern (Specify)	n, atreet, fact	ory, offic	•	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				Route Number,	
COMPLET	29a. CERTIFIER (Check only one) 1 X CERTIFYINO PHYSIC (Check only one) 2 MEDICAL EXAMINES										a) and manner as stated.	
	29b. SIGNATURE AND THE OF CERTIFIER	/										
BE	290. SIGNATURE WHILE THE CENTRE IN	26/11	in			29c. LICENSE NU					(Month, Day, Year)	
2	30. NAME AND ADDRESS OF DERSON WHO	COMPLETED CALLS	OF DEATH PTEN OF T	one Def-41		D1381	.8		1 Oc	tobe	r 30, 1995	
	Gary P. Fisher, N	4.D. 5530	Wisconsi		nue,	#1443,	Chev	y Chas	se, MI) 2	0815-4486	
	31. DATE FILED (Month, Day, Year) NOV 01 1995	January Santan										

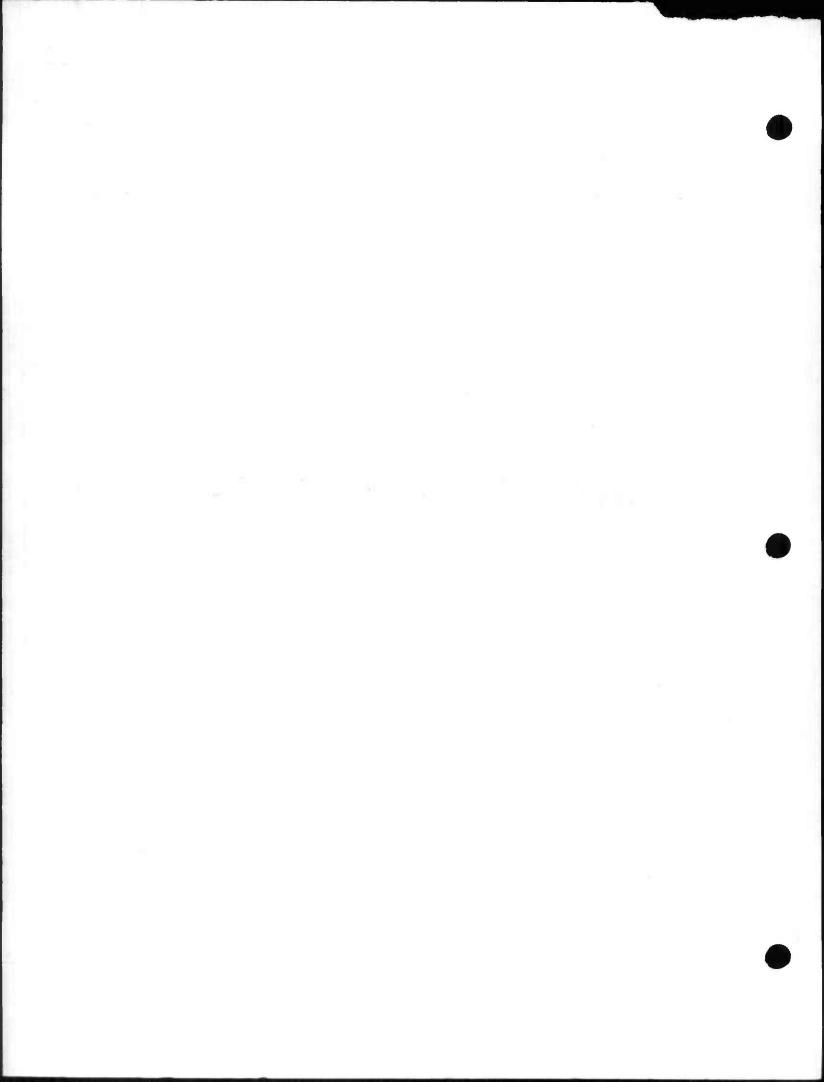
Prair .

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MA			OF DEATH	MENTAL	HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	y yı	3.	TIME OF DEATN	٦
	CATHERINE		VHITE			Nove		, 199		L1:40 A.	м
	4. SOCIAL SECURITY NUMBER 067-32-9860	5, SEX 1 M 2 (X) F	B. AGE (In yrs. last birthday	MONTHS C	EAR IF UNDER 24 HRS. AYS HOURS MIN.	7. DATE (Dey. Year) 22, 1		Country)	CE (State or Foreign	- 1
	9a. FACILITY NAME (If not institution, give s		90 YRS.		OWN OR LOCATION OF D		22,	905 I			\dashv
OR	Circle Manor Nurs	sina Home		Kensi				Monte			
בַּ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c. C	ITY, TOWN OR				10d. INSIDE CITY			╡
DIRECTOR	Maryland Howa	ard		ghland						LIMITS?	ŀ
AL.	10e. STREET AND NUMBER	- 1			101, ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?			٦
FUNERAL	7131 Mink Hollow				20777			Unite			_
	11. MARITAL STATUS 1 Never Married 2 Merried		EVER IN U.S. ARMED YES 2 X NO	II y	S DECENDENT OF HISPAI ea, specify Cuben, Mexico	an, Puerlo R		or No — 14.	Black, WI Specify:	American Indian, hite, etc.	-
ВУ	3 🕅 Widowed 4 🗌 Divorced	# 100, GFE 181			YES ZYNO Specif				Wh	nite	
TEC	15. DECEDENT'S EDU- (Specify only highest grade	completed)	16a. DECEDENT (Give kind of life, Do NOT	'S USUAL OCC: of work done dur use retired.)	JPATION ing most of working	16b.	KIND OF BUS	INESS/INDUST	FRY		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)	Seamstr			S	elf-en	ploye	d		
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, A	fiddle, Maiden	Surname)			┪
BE (James	Fi	itzgerald		Marg				O'Bri	Len	Ц
6	196. INFORMANT'S NAME (Type/Print) Maureen W. Nest	ni++			ollow Rd.		hland,				1
	AND METHOD OF DISPOSITION		20b. PLACE AND DAT			DATE		CATION — City		State	\dashv
	1 Burlai 2XXCremation 3 ham 4 Donation 5 Other (Specify)	oval from State	cemetery, cremetory of Chesapea	rotherplece) ake Cre	matory, In	c 11-	3 Bel	tsvil.	le, N	4D	
	21. SIGNATURE OF FUNERAL SERVICE LIC	A MI	/	Rap	me and address of FA	Servi	.ces, F	P.A.			\neg
	1 Off -1	& UM	m00827	933	Gist Ave.	Si	lver S	Spring		20910	
	23. PART I Enter the diseases, or a shock, or heart failure.	complications that List only one caus	caused the death. Do e on each line.	not antar th	a mode of dying, aud	ch as card	llac or reapli	ratory arrest	,	Approximate interval Between	
	iMMEDIATE CAUSE (Finel disease or condition	ani	ot	2000						Onset and Deati	h.
	resulting in deeth)	o	OR AS A CONSEQUENCE		ona						\exists
N	Sequentially list conditions,	bV									
ATIC	if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (C	OR AS A CONSEQUENCE	OF):							-
띮	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A CONSEQUENCE	OF):							1
CERTIFICATION	reaulting in death) LAST	d									_
AL C	PART II. Other algolficant condition	s contributing to	leeth but not resultin	g in the unde	eriying ceuse given in	Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS	,
DIC/	alsheimer.	s deme	inlia				1 YES 2		co	AILABLE PRIOR TO MPLETION OF CAUSE DEATH?	-
ME									1[YES 2 NO	-
PHYSICIAN: MEDIC	DID TOBACCO USE CONT	KIBUTE TO CAU	28. PLACE OF DI		Control of the Contro	иП					4
SICI	EXAMINER? 1 YES 2X NO	HOSPITAL:	ER/Outpatient 3 DOA	OTHER:	g Home 5 🗆 Realdence	8 🗆 Other	r (Specify)				
РНУ	27. MANNER OF DEATH	28a. DATE OF II (Month, Day		TIME OF 2	Sc. INJURY AT WORK?	28d. DES	CRIBE HOW II	NJURY OCCUP	NED		٦
Β¥	2 Accident investigation	28a RI ACE OF	INJURY — At home, fern	M .	1 YES 2 NO	201 1 00	ATION 101				4
	3 Suicide 8 Could not be 4 Homicide determined	building, e	tc. (Specify)	ii, atreet, ractor	, omca		ATION (Street a or Town, State)	na Number or	Hurai Houte	numoer,	
Ë	29e. CERTIFIER (Check only	ICIAN: To the best of r	ny knowledge, death occi	urred at the tim	e, data and pleca, and du	e to the cau	rse(a) and man	ner sa stated.			H
COMPLET	(oneon only				nion, death occured at the				ause(s) en	d menner as stated.	
BE C	296 STGNATURE AND TITLE OF CERTIFIE	y ou	16-		29c. LICENSE NU	IMBER				onth, Day, Year)	1
TO B	39 NAME AND ADDRESS OF PERSON WH	1	N	24.5	0340	32		No	v. 2	, 1995	
	TEANNE PA	SUER P			agut Ave.	Kens	sinator	a. MD	2089	95	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	I'S SIGNATURE		-3 ,,,			-,			1
	NOV 03 1995	, John Da	uther hardall								



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6 Injury, CERTIFICATION

PHYSICIAN: MEDICAL

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32. REGISTRAR'S SIGNATURE

Julia Davidson Rendall

30. NAME AND ODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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31. DATE FILED (Month, Day, Year)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH TRE ILSON :50A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign NOV 11,1900 219-26-3962-A DAYS 1 M 2 A 94 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Lorien Nursing And Care Columbia Howard RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard Clarksville 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 5924 Ten Oaks Rd, 21029 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexicon, Puerto Ricon, etc.) 14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Merried IF YES, DIVE WAR OR DATES 1 YES 2 NO Specify: 3 Vidowed 4 ☐ Divorced SPECK Black 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 6th Grade Housewife None 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Alexander Hebron Harriett A. Holland 19e. INFORMANT'S NAME (Type/Print) (Son) 19b. MAJLINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5926 Ten Oaks Rd, Clarksville, Md 21029 Mr Harold Wilson 20a. METHOD OF DISPOSITION
125 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State HODKINS Church Cem. 11/2 Highland, Md 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, 23. PART I. Enter the diseases, or complications that caused the des shock, or head failure. List only one cause on each line. ses, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrast, Interval Batween **IMMEDIATE CAUSE (Final Onset and Death** disease or condition resulting in death) ARDIOMYUDATHY
DUE TO (OR AS A CONSEQUENCE OF): HEONT yeou? WIFA CONGESTUT FALLINE AONTI STENUSIS Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury HY OF AT A CONSEQUENCE OF: that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? DEMENTIA ATHENOS (LEMOSI) 1 - YES 2 -1 TES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NOVEL UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4) Linuxing Home 5 - Reeldence 8 - Other (Specify) 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 26t. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 8 Could not be 4 Homickie 29e. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER

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1995

3. TIME OF OEATH

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Approximate Interval Between **Onset and Death**

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF OEATH?

2. DATE OF DEATH MONTH October 6

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1 - FOR STATE REGISTRAR

Laura

1. DECEDENT'S NAME (First, Middle, Last)

Etta

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	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.	last hirthdays) #5	UNDER 1 YEAR	IF UNDER 24 HRS.	COTOBE		19		1550
	215-18-4425	1 M 2 F			THE DAYS	HOURS MIN.	7. DATE OF I (Month, De	ly, Year)		Country)	.ACE (State or Foreign
	9e. FACILITY NAME (If not institution, give	street and number)	87	9b.	CITY, TOWN	OR LOCATION OF DE	Sept			ITY OF OEA	aryland
	PENINSULA REGI	ONAL MEDI	CAL CE			ALISBURY				COMIC	
	10e. STATE 10b. COUNT	Υ		10c. CITY, TO	WN OR LOCA	TION				10	Od. INSIDE CITY
l	Maryland Wice	omico		Sa	lisb	ıry				1)	YES 2 NO
	10e. STREET AND NUMBER				10	I. ZIP CODE			10g. CITI2	ZEN OF WHA	AT COUNTRY?
_	110 First Str					21801			U.S	S.A	
1	1. MARITAL STATUS Never Married 2 Merried Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	ARMED NO	If yes, sp	CENDENT OF HISPAN ecify Cuben, Mexica 2 NO Specify	n, Puerto Rica	pecify Yes or n, etc.)	r No-	14. RACE — Black, V Specify:	- American Indian, White, etc.
	15. OECEDENT'S EOU		16a.	DECEDENT'S USU	AL OCCUPATION	ON	16b. KIN	ID OF BUSIN	IESS/IND	USTRY	Black_
J	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +	,	(Give kind of work i life. Do NOT use reti	done during mo ired.)	ast of working					
	12			Domest	ic			None			
17	7. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Midd	le, Maiden Su	rname)		
	James Dashiel:	i e				Stell:	a Win	der			
	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING ADD	RESS (Street a	and Number or Rural I	Route Number, (City or Town,	State, Zip	Code)	
	Edith Coulbon	urn		26760	Crook	ed Oak	Lane	Hebr	on,	Md.2	21830
1	20e, METHOD OF DISPOSITION SEBURIAL 2 Commention 3 Rem	oval from State	20b, PLAC	E AND DATE OF DI	SPOSITION (Ne		OATE			Sity or Town	
4	□ Donation 5 □ Other (Specify)		Spri	nghi11	Gard		1728	Heb	ron	Md.	
2	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE				ND ADDRESS OF FA					
	Hladyo B	Stews	TA			ert Fund West Rd			. W	3 216	201
	23. PART I. Enter the dispesses, or	complications that	causad the	deeth. Do not a	nter tha mo	da of dying, suc	as cardiac	or respira	tory arm	1 . Z 1 C	Approximate
	shock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one ceu	se on each II	ne.		C		•	•		Interval Betwee
	disesse or condition	1	-	1.1.							Conser sing be
	resulting in death)	DUE TO	OR AS A CONS	SEQUENCE OF:	BQ						742.
	_	. 10	-00-	Gane	- /	dans	lac	Dr.			100
	Sequentially list conditions, f sny, leading to immediate	DUE TO	OF AS A CONS	SEQUENCE OF):		14	100	7			1927.
-	CAUSE, Enter UNDERLYING CAUSE (Disease or Injury	· ch	-	ce a	ulce	7					nech
1	that initiated events	OUE TO	OR AS A CONS	SEQUENCE OF):		-					
	resulting in death) LAST	d									
	PART II. Other significant condition	s contributing to	death but no	t resulting in th	e underlylni	a cause alven la	Bort I 24	. WAS AN AU	TOBOY	1 045 111	
		_			- oncorrying	ande Attell III		PERFORME	ED?	AV	ERE AUTOPSY FINDIN MILABLE PRIOR TO OMPLETION OF CAUSE
							1[YES 2	NO		F OEATH?
	DID TORACCO LISE CONT	DIDLITE TO CA	ICE OF SE	ATIL WES F	T No F	1 11110-00-00-0				1.	YES 2 NO
. 2	DID TOBACCO USE CONT			ACE OF DEATH (C			ч Ц				
	EXAMINER?	HOSPITAL:		ОТ	HER:						
	27. MANNER OF DEATH	1.2 Inpetient 2 28e. OATE OF		3 DOA 4 D	Nursing Hom 28c. INJ	e 5 Residence	-		IMM AA-		
_	1 Alatural 5 Pending	(Month, Da		INJURY	wo	PRK?	28d. DEŞCRII	BE HOW INJU	JRY OCC	UREO	
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At	home, term, street			281. LOCATIO	N (Street end	Number	or Rural Rout	te Number,
	4 Homickle determined	building, 4	Mc. (Specify)				City or To	wn, State)			
29	Check only	CIAN: To the best of	ny knowledne	death occurred ==	the time. date	and place, and due	to the course's	and means	7 Ap mint-	4	
	(Check only one) 2 MEDICAL EXAMINE										nd manner se stated
-	29b. SIGNATURE AND TITLE OF CERTIFIE				, , , , , ,						
	172	5/1	*			29c, LICENSE NUM	7,19	2	9d. DATE	SIGNED (M	onth, Day, Year)
30.	NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OE OEATH "T	TEM 27) (Fine D		- 1	14		/	1/2	1/18
	WILLIAM KOB	115. M.S	2. //	04 /EA	LANA	V DR.	3.11.15.1	Wy.	AD	21801	/
٥,	OCT 26 1995	32. REGISTRAF	WLOC PO	delle	•			/			
	001 20 1333	A man									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

RIGH

DHMH-18 Rev 1/89

B.K.S

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatle event, the medical examiner must be notified at once. 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	ITEMS:	23 PART I	, 27, PER	MEO F	ILM (G-730	12/13/95	t.t		10	34303
	FOR STATE REGISTRAR	STATE OF M	MARYLAND /	DEPAR	TMEN'	T OF H	EALTH AND I	MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		W545	3. TIME OF DEATH
	JONATHAN	F.	W	ALR	HTO			NOV. 6	199	95 ^{AR}	1044 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 5, 19	005	8. BIRTH Country Mary	
	9a. FACILITY NAME (If not Institution, give st			_	9h CITY	TOWN O	R LOCATION OF DE			NTY OF DE	
TOR	Malchom Grow Medi		er			\FB		23111			GEORGES
DIRECTOR	10a. STATE 10b. COUNTY					or Locat	lboro	<u>-</u>			10d, INSIDE CITY LIMITS?
						101	ZIP CODE	-	100 CIT	IZEN OF W	1 ☐ YES 2 🔀 NO
RA		Daniera				1			11.		
FUNERAL	12302 Old Colony		T EVER IN U.S. ARI	MED	12	WAS DEC	20772	VIC ORIGIN? (Specify Yes			States - American Indian,
ВУ	Never Married 2 Married 3 Widowed 4 Divorced	YES 2 N			If yes, spe		n, Puerto Rican, atc.)	dr No.	Specific Whi	r, White, atc.	
15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working											
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	life	Do NOT u	se retired.)	ourng mo	or or morning				
MP	N/A		N/	'A				N/A			
흥	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, Maiden	Sumame)		
BE	James Franklin Wa	lroth					France	es Cuaresma	3		
2	19s. INFORMANT'S NAME (Type/Print)		19t	. MAILING	ADDRES	\$ (Street a	nd Number or Rural i	Route Number, City or Tow	n, State, Zij	Code)	
	Maj. James F. Wal	roth						re, Upper 1			
	20a. METHOD OF DISPOSITION 1X Burlel 2 Cremelion 3 Reme	oval from State	cemetery, crei	metory or a	ther piece:	ì	me Nov 10,	11777		City or To	
	4 Donation 5 Other (Specify)		Resur	rect	10n	Ceme	etery	C	Linto	m,Ma	ryland
	21, SIGNATURE OF FUNERAL SERVICE LIC	ENSEE						CILITYLEE Fund			
	1 1 TK 5. 0	*			[0]	ld Al	exandria.	a Ferry Roa	ad, C	lint	on, MD
	23. PART I. Entar the diseasea, or o				not ania	r tha mo	da of dying, suc	h as cardiac or resp	iratory ar	rest,	Approximata
	shock, or heart failure. IMMEDIATE CAUSE (Final	List only one cal	ise on eech line								Onset and Death
	disease or condition resulting in death)	PNEUMO	NIA								
	rooming in acuti,	DUE TO	(OR AS A CONSEC	DUENCE O	F):	-					
CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate	bDUE TO	(OR AS A CONSEC	DUENCE O	F):			*			
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	С.									
트	that initieted svents	DUE TO	(OR AS A CONSEC	DUENCE O	F):			•			
	resulting in death) LAST	d									
- 1	PART II. Other significent condition	s contributing to	deeth but not r	esulting	In the u	nderiving	ceuse alven in	Part I. 24a. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL							g 00000 g.ven m	PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ă								1 TYPES :	NO I		OF DEATH?
Σ	DID TOP ASSOCIATE SONT	DIDLITE TO CA	LICE OF DEA	-11 14		NO E	1				1 YES 2 NO
Ä	DID TOBACCO USE CONT	KIBUTE TO CA		E OF DEA			UNCERTAI	NLI			
<u> </u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE						
ΙΥS	1X XVES 2 NO		MR/Outpatient 3			_		6 Other (Specify)			
BY	2 Accident Investigation 3 Suicide B Could not be	28s. PLACE (F INJURY — At ho	ma, larm,	straet, fac	tory, offic	1	281. LOCATION (Street		er or Rural F	Route Number,
즲	4 Homicide determined										
1	29a, CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the heat o	my knowledge de	ath occur	red at the	time det-	and place, and due	10 the cause(s) and ma	Door or of	rted.	
COMPLET	0.000.2000.00										s) end manner as staled.
- 1	191/ BIGNATURE AND TITLE OF CERTIFIE	1					29c. LICENSE NU	MBER	29d DAT	TE SIGNED	(Month, Day, Year)
BE	1000	Work o	- aller				O.C.M.				9,1995
일	30 NAME AND ADDRESS OF PERSON WH	O COMPLETED CALL	SENSE DEATH ATE	M 270 (5:00	Orint)		U.C.M.	• Li	. 14(J V •	711777

111 Penn Street, Baltimore, Maryland 21201

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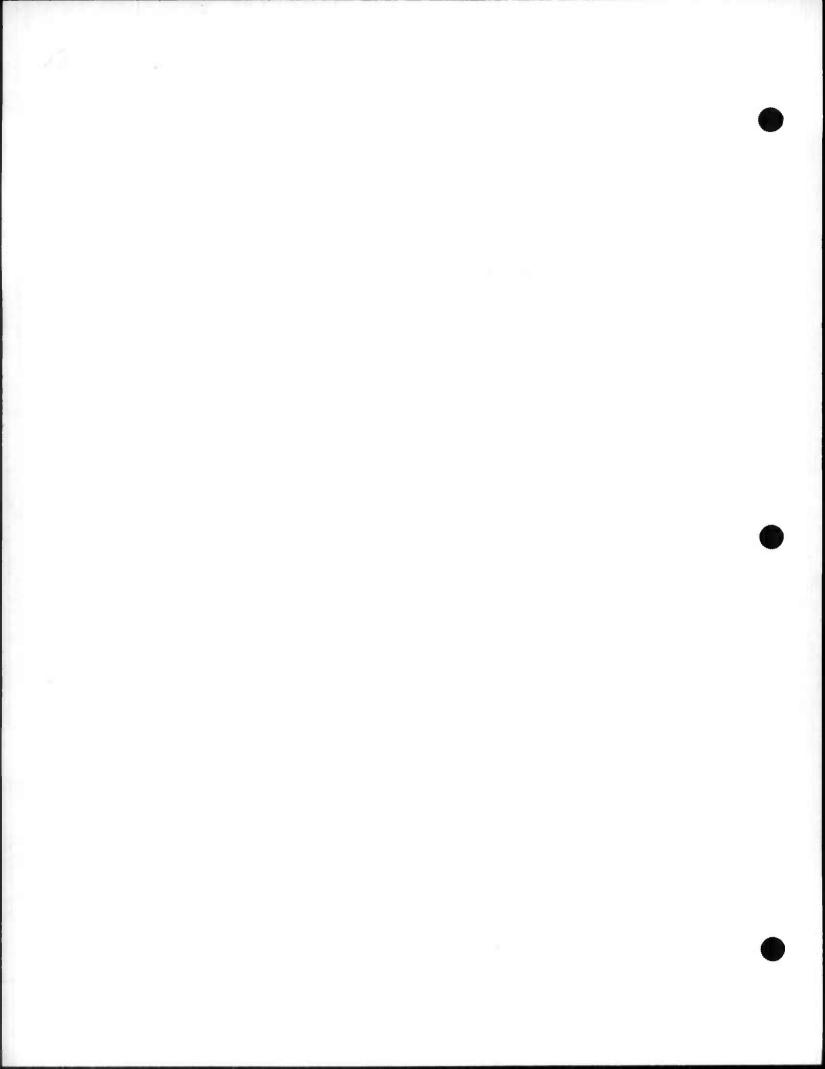
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		FOR 1 - STATE REGISTRIAR	STATE OF	MARYLAI	ND / DEPAI CERTIF					MENTAL HYGI		0 0	4004
		1. DECEDENT'S NAME (First, Middle, La	ist)		CERTIF	ICATE	OF	DEAL		2. DATE OF DEATH			TIME OF DEATH
		Herbert Wil	liam Wo	oods						October	DAY	YEAR 995	4:30 A M
		4. SOCIAL SECURITY NUMBER	5. SEX		yrs. last birthday)	IF UNDER 1	YEAR	IF UNDER		7. DATE OF BIRTH	30 1		ACE (State or Foreign
		054-07-0365	ĭX M 2 □ F	7	6 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year May 20		Country)	
3 should		9a. FACILITY NAME (If not institution, gi	ve street and number)			9b. CITY, 1	OWN C	R LOCATIO				IN 2 W	York
	E C	83 Hackney Dr	ive					inst				roll	
1, 2,	5	RESIDENCE OF DECEDENT									Cui	TOTT	
Sages	DIRECTOR	10a. STATE 10b. COU				Y, TOWN OR						10	d. INSIDE CITY
ii.			rroll		Me	estmi	-					1	YES 2X NO
020 physician. burial-fransit permit. Pages 1,	FUNERAL	10e. STREET AND NUMBER					100	ZIP COOE			×11		T COUNTRY?
ian. trans	밀	83 Hackney Dr						2115				ited	States
20 hysici urial-	급	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEOE FORCES?	YES YES	2 NO					C ORIGIN? (Specify	Yea or No —		American Indian, Vhite, atc.
The b	B	3 Widowed 4 Divorced	WWII 8			1[YES	2 X) NO	Specify:			Specify:	white
™ 8 8	8	15. DECEDENT'S E	DUCATION		6a. DECEOENT'S	USUAL OCC	UPATIO	IN .		16b. KIND OF	RI ISINESS/INI	DUSTRY	WILLCE
		(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4 or 5			work done du			g	Too. Kill D	3001112331111	JOSINI	
	호	12			salesm	ian				recor	d suc	polv	
MARYLAND 21 retained by the hospital or 5 should be detached for unouffied at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAN	E (First, Middle, Maid		F - I	
7 & A	BE	John	Woods					Ag	nes		Na	gele	
MAR retained 5 should notified	0 B	19a, INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Street a	nd Number	or Rural Ro	oute Number, City or			
	۲	Florence Wood	S		83 H	lackn	ey	Dri	ve,	Westmi	nster	, MD	21157
BALTIMORE, I ter death. Page 6 may be the funeral director, page 9 yal.		20a. METHOD OF DISPOSITION X Buriel 2 Cremation 3 R	emovel from State	20b. PL	LACE AND DATE	OF OISPOSIT					LOCATION -		
MORI ge 6 may frector, p		4 Donation 5 Other (Specify)								an's O	winas	Mi 1	ls. MD
ALTIMI death. Page funeral dire i.		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. NA	ME AN	D ADDRES	S OF FAC	ILITY	_		
AL deatl fund		Katherine 4	Pristo - Au							ral Hom			
C 3 2 a		23. PART I. Enter the diameses,	or complications the	et caused th	he death. Do	not enter th	e mod	da of dvir	ng. auch	an cerdiec or re	Wes	tmin	ster, MD
- d d		snock, or neert failui	e. List only one car	use on aach	h ilne.	1				ma 0010100 07 10	spiratory an	reat,	interval Between
4 ± 8 €		iMMEDIATE CAUSE (Final disease or condition	1011	(91	20/1	//1/	m	221	m				Onglet and Death
1760 completely fille cemation, cevent, the		reaulting in death)	DUE TO	(OR AS A CO	ONSEQUENCE O	FI:	15	// /	100	>			OVILS
Z 2 5 - 0	2		- 50										į i
OX 68: te be execute sician and conion to burial	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	(OR AS A CO	ONSEQUENCE O	F):							
BOX cate be ex hysician a s prior to	8	cause, Enter UNDERLYING CAUSE (Disease or injury	C.										
o.O. B certificat nding phy Hygiene p	E	that initiated eventa	DUE TO	(OR AS A CO	ONSEQUENCE O	F):							
S, P.O. B(death certificate attending physiental Hygiene print), or other th	H	resulting in death) LAST	d										
		PART II. Other aignificent condit	lona contributing to	death but	not resulting	in the unde	rlulaa	Course of	lun in E	hard I are uma		1	
2 1 8 E	CAL	Cormery	aptori	1 11	CON		riyitiy	ceuse gi	IVEIL III F	D.C.O.	AN AUTOPSY ORMED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO
RECOF requires that een signed b of Health ar shows any	MEDIC/	Minmil	10 2001	Fail 1	1100					1 [] YES	2 NO		MPLETION OF CAUSE DEATH?
w requires that been signed I for the signed I for the signed I shows any	Σ	DID TOPACCO LICE COA	ITDIDLITE TO CA	USE OF	CIOCE	c [] th	. 100			_		1	YES 2 NO
Se as a	PHYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL			PLACE OF DEAT	S N		UNCE	ERTAIN				
F = = = =	길	EXAMINER?	HOSPITAL:			OTHER:		7					
ICIA the	₹	27. MANNER OF DEATH	1 Inpetient 2		ent 3 L DOA 28b. TIM	4 Nursin	g Home		- V	Other (Specify)		With the same	
NG PHYSIC frer this ce sath with th		Natural 5 Pending	(Month, E		INJ	URY	WOF	RK?		28d. OEŞCRIBE HO	V INJURY OC	CURED	
OING F After death	B	2 Accident Investigatio	200 PLACE C	OF INJURY —	At home, farm, s					201 LOCATION (O-		0 10	
	6	4 Homicide 8 Could not to determined	" Dunging.	atc. (Specify)	terre, terrer, 1	rectory	, Jinca			281. LOCATION (Stre City or Town, Str	n and NUMber (e)	or numi Rout	vumber,
DIVISION OR ATTENOING I DIRECTOR: After hours after death	COMPLET	29e. CERTIFIER	VOICE AND THE STATE OF THE STAT										
절절었는	MP	(Check only CERTIFYING PH	YSICIAN: To the best of										
HOSPITAL FUNERAL within 72 I	8		NER: On the basis of	ANTONIA PROPERTY		n, in my opir	non, da	-				- 7	1
물 물 을 입	H	296. SIGNATURE AND TITLE OF CERTIFIC	11/	11.	12	20		29s. LICEN	NSE NUMB	(11)	29d. DAT	E SIGNED (M	onth, Dev. Year)
2 2 3 2	2	30. NAME AND ADDRESS OF PERSON	1.170	-du	100	/		11	156	0014	1 -/	13	1/45

32. BEGISTRAR'S SIGNATURE
Jalia d'Audign Realell

31. DATE FILEO (Month, Day, Year) NOV

1995



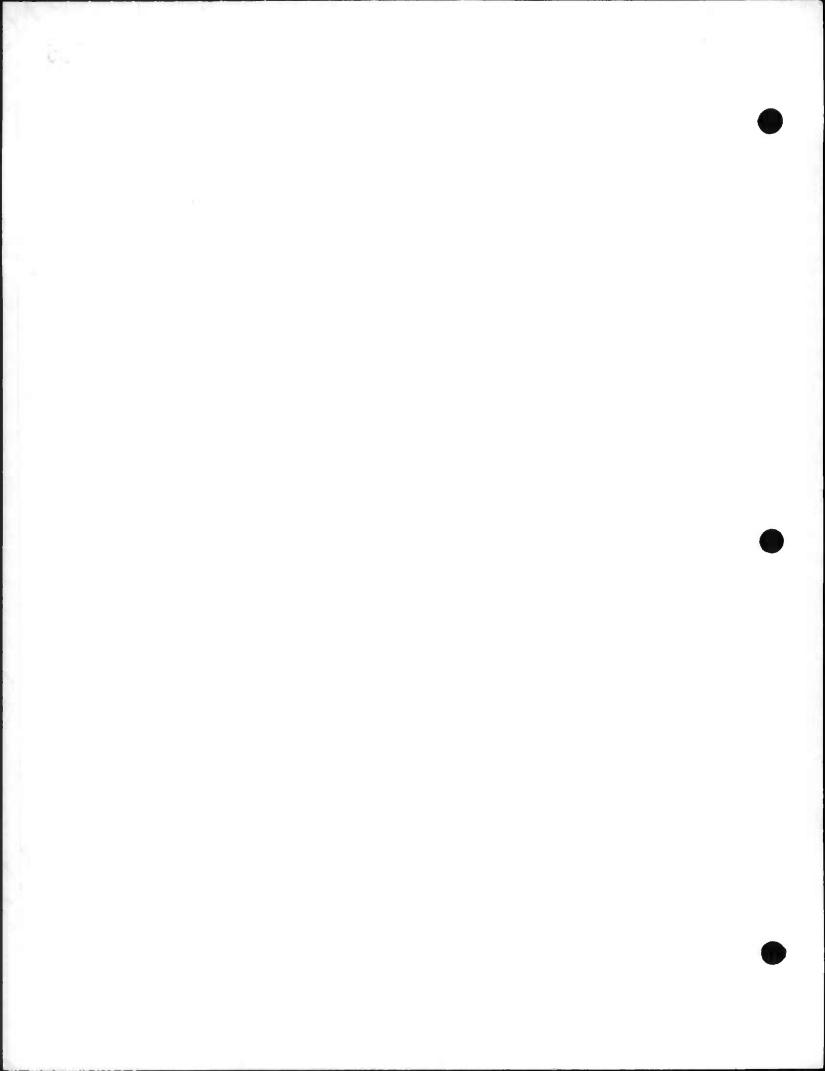
Pages 1, 2, 3

permit.

DALISMORE, MA	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retain	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sh be filed within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notify
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DIVIDIGITATION OF THE PROPERTY, P.O. DOA 50/00	CIAN	ertific the S	10
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	OR	DIRE	tem
	TAL	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Debt, of Heath and Mental Hydiene prior to burial, cremation, or removal.	=
	OSP	ithin	N.
	平	H P)RT
	10	O The	MPC
	-	- 0	=

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Daniel ar 0 Oct M . OCTO 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last hirthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 213-16-00 1 M 2 | F DAYS HOURS Maryland -3 9e. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH Washington County Hospital RECTOR Washington Hagerstown RESIDENCE OF DECEDENT 10a, STATE 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 0 YES 2 NO 10a. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 322 South Potomac Street U.S.A. 21740 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 14. RACE — American Indien, Bleck, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced white ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL security guard security service once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) Charles E. Wolfe Ħ Ruth Harne notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21740 2 Mrs. Gertrude Ida Wolfe 322 South Potomac Street, Hagerstown, Maryland e 20a, METHOD OF DISPOSITION
1 △ Burlel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must b DATE 20c. LOCATION - City or Town, State Funkstown Cemetery 10-30-1995 Funkstown, Maryland 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL-SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, MD 21740 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ Hemolytic old Hagluting lutinin resulting in death) event, Lyland 10 traumatic MMUNP CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF if sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in dasth) LAST 9 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY any 1 MONON tailure 1 TYES 2 THO OF DEATH? Shows 2 Anasarca 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 1 PHYSICIAN: UNCERTAIN | 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) ltem HOSPITAL: OTHER: 1 YES 2 NO npetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Yeer) 28c. INJURY AT WORK? 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, Natural М ВУ 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) ETED | 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 6 Could not be item 28 4 Homicide determined 29e. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 __ MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 出 6 2 ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3 leveland 6

32. REGISTRAR'S SIGNATURE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a found and death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within TS burial with the family hydien prior to burial, tremation, or removal.

MEMORPHANT IN THE PAGE OF THE BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH PEG NO

	REGISTRAR		CERTIF	ICALE OF	DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	9 199							
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGI	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		IRTHPLACE (State or Foreign	
	220-64-1447	1 🗌 M 2 💢 F	77 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) April 8, 1	C	ountry) aryland	
	9a. FACILITY NAME (If not institution, give st			9b. CITY, TOWN C	OR LOCATION OF O	EATH	9c. COUNTY C	OF DEATH	
DIRECTOR	Washington County	Hospital		Hagers	stown		Washi	ing ton	
l m	10s. STATE 10b. COUNTY		10c. CI	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY	
	Maryland Frede	rick	Sı	nithsburg	5			LIMITS?	
FUNERAL	100. STREET AND NUMBER 4643 John Draper	Road		101	21783		10g. CITIZEN OF WHAT COUNTRY? USA		
5	11. MARITAL STATUS	12. WAS DECEDENT EVER				NIC ORIGIN? (Specify Yes		RACE — American Indien,	
₩	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 TYES		If yee, specify Cuben, Mexicen, Puerto Rican, etc.) 1 YES 2 NO Specify: White, etc. Specify: White					
TED	15. DECEDENT'S EDUC (Specify only highest grade of		tea. DECEOENT'S	USUAL OCCUPATIO work done during mo- ise retired.)	ON st of working	18b. KIND OF BUS	SINESS/INDUSTR	YY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homemake			Own Hon	ne		
2 5	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)		
BE C	Russell H. Lewis					Harriet T	-		
10	19a. INFORMANT'S NAME (Type/Print) Donald Allen Will	ard				Route Number City or Town		, WV 25419	
TO BE COM	20g. METHOD OF DISPOSITION 1 🔁 Burlel 2 🗆 Cremation 3 🗆 Remo		b. PLACE AND DATE			DATE 20c. LO	CATION — City of FOXVIII	r Town, State le, Maryland	
ехэшшес	21. SIGNATURE OF FUNERAL SERVICE LICE				ID ADDRESS OF FA			n Street	
exal	hitty L.	Keckath	,	Ricket	ts Funer			lle, MD 21773	
	23. PART i. Enter the diseases, or ci	omplications that cause	ed the death. Do	not enter the mo	de of dying, suc	h as cardiac or respi	retory srrest,	Approximate	
	shock, or heart fallure. L IMMEDIATE CAUSE (Fine) disease or condition	.ist only one cause on	each line.	a D.	+ to	lul		Interval Between Onset and Death	
H.	reaulting In death)	DUE TO (OR AS	A CONSEQUENCE O	D: 1	1 7000	1		I 0015	
Z Z	Sequentially list conditions,	us too	Parafa	HUY	- Min			/	
CERTIFICATION	if any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE O	F):					
IFIC I	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):					
E	resulting in death) LAST	l							
	PART IL-Other aignificant conditions	contributionto doub	but not offere	Direction de student	t t	0.21 2			
EDICAL C	PART II Other aignificant conditions	Te dolar	The Time	er use underlying	cause given in		MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE	
		1				1 □ YES 2	₽W0	OF DEATH?	
N. W	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH Y	S NO	UNCERTAIL	N D			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one) OTHER:					
YS I	t YES 2 NO	1 Inpatient 2 - ER/Ou	tpatient 3 DOA		e 5 🗆 Residence	8 Other (Specify)			
IK .	27. MANNER OF DEATH 1 Nitural 5 Pending	(Month, Day, Year)	28b. Tife IN.	JURY WO	RK?	28d. DESCRIBE HOW IF	NJURY OCCURED		
B	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJUR	Y — At home, farm,		ES 2 NO	28f. LOCATION (Street e	and Number or Bu	onl Boute Number	
ETED	4 Homicide determined	building, atc. (Sp.	ecify)			Cify or Town, State)			
COMPLET		CAN: To the best of my kno						se(e) and menner se stated.	
ш	296. SIGNATORIE AND TITLE OF CERTIFIED	0			29c NCENSE NUM			NED (Month_Day, Year)	
TO BI	Norman gu	<u> </u>			17966	4/	► 10-18	(1)	
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH WEM 27 Type	Clivela	THE Son	Barent	in hel	20785	
	31 10 the fired (Withhale 3 day) Jan	REGISTRAN SIG	Call Call		1	/	1	700	

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.	FE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmir. Pages 1.2 3 servaled	ed within 72 hours after death with the State Oept, of Health and Mental Hygiene prior to burial, cremation, or removal.	DRTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that	TO THE FUNERAL DIRECTOR: After this certificate has been signed by	be filed within 72 hours after death with the State Dept. of Health ar	IMPORTANT: It item 28 is marked, or item 23 shows any

R. 5. Guedenet 31. DATE FILEO (Month, Day, Year) OCT 2 5 1995 July

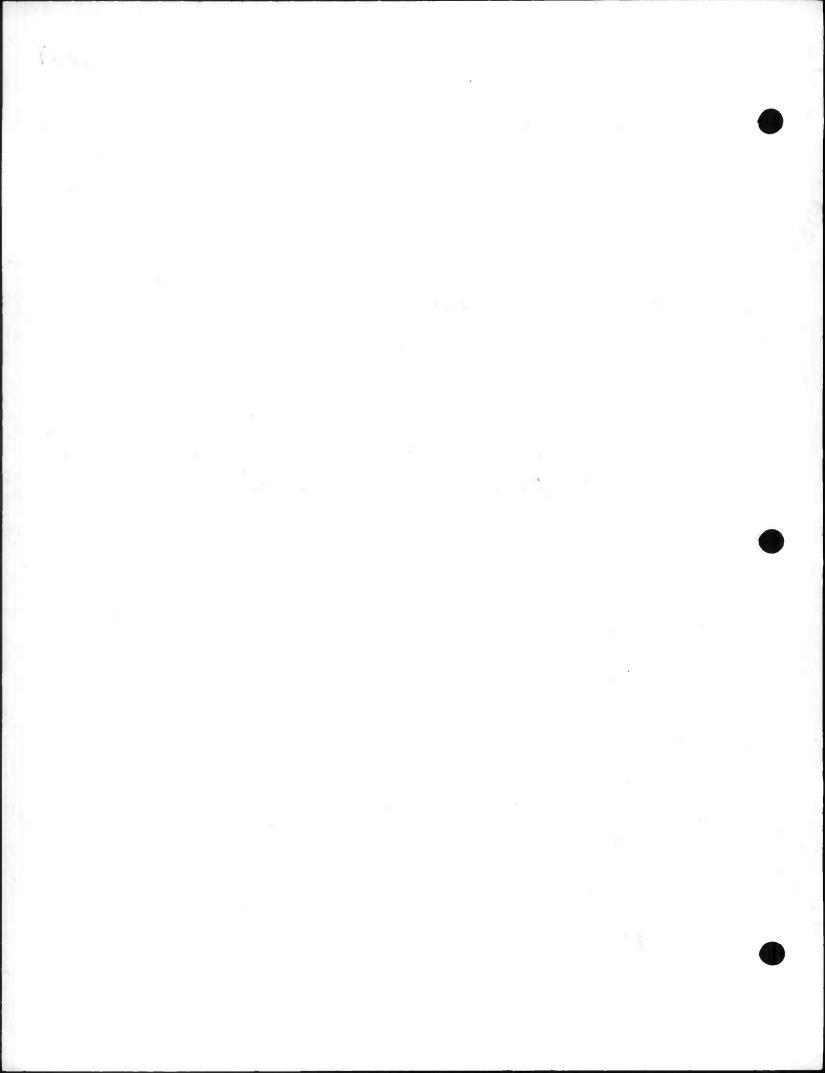
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32. REGISTRAR'S SIGNATURE

							7	J ,	34587	
FOR STATE REGISTRAR	STATE OF MARY	YLAND / [DEPARTI	MENT OF H	EALTH AND					
1. DECEDENT'S NAME (First, Middle, Last)				_		2. DATE OF DEATH		3	. TIME OF DEATH	
RAY FRANKL				23	0	2012 PH				
4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	GE (In yrs. last t	birthday) II	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	03		ACE (State or Foreign	
220-16-3815	1 🔀 M 2 🗌 F	77	YRS.	ONTHS DAYS	HOURS MIN.		Country)			
		9	b. CITY, TOWN O	R LOCATION OF D		_				
		- 1								
RESIDENCE OF DECEDENT	1		HA	GERSTOWN	V	V	VASHII	NGTON		
10a. STATE 10b. COUNTY	-		10c. CITY, 1	TOWN OR LOCATE	ION			10	Od. INSIDE CITY	
MARYLAND V	VASHINGTON			KEEDYS	VILLE			- 1	LIMITS?	
10e. STREET AND NUMBER							10g. CITIZ		-	
5607 RED HILL ROZ	AD				21	756		TT	.S.A.	
11. MARITAL STATUS	12. WAS DECEDENT EVE			13. WAS DECE			or No.			
1 Never Merried 2 Married			1	If yes, spe	cify Cuban, Maxica	an, Puerto Rican, etc.)			White, etc.	
3 Wildowed 4 Divorced				1 110	a garaca	y.		эреспу:	WHITE	
15. DECEDENT'S EDUC	ATION	16a. DECE	EDENT'S US	SUAL OCCUPATIO	IN .	16b. KIND OF BUS	SINESS/INDI	USTRY		
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	o NOT use n	x done during mos wifred.)	st of working					
8			FAR	MER		OWN DA	IRY I	FARM		
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)			
JAMES WESLEY WHI	IPP				MAMIE	C. BROWN				
19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING AD	DDRESS (Street an			n, State, Zip	Code)		
FLORENCE V. WHIPE	P	56	507 RI	ED HILL	ROAD, F	KEEDYSVILLE	E. MD	217	56	
20g, METHOD OF DISPOSITION	:	20b. PLACE AN	D DATE OF C	DISPOSITION (Nan						
4 Donation 5 Other (Specify)					10/					
21. SIGNATURE OF FUNERAL SERVICE LICE	MEE	LILLICAT	111 (1				DIUVI	,	THILLTHIND	
Now OM- 8	ha Dat	Daul M Doan PACT FINE					7606 Old National Pike			
rear 11/ No						Boons	boro,	MD	21713	
ahock, or haart failure. L	implications that cause or list only ona cause or	sed tha deat 1 each line.	th. Do not	anter tha mod	de of dying, auc	h as cardiac or reapi	ratory arre	eat,	Approximata Interval Between	
IMMEDIATE CAUSE (Final	Λ				. /	1			Onset and Death	
reaulting in death)	Corelina	20000	1	las auckent						
DUE TO (OR AS A CONSEQUENCE OF):										
	DUE TO (OR A	S A CONSEQU	ENCE OF):	er a	Mille	nV.			5 days	
Sequentially list conditions b.			ENCE OF):	er a	use	nV			5 day	
Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS		ENCE OF):	es a	u.s.	nV.			5 days	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS	S A CONSEOU	ENCE OF):	er a	lleste.	nd.			5 day	
If any, leading to immediate cause. Enter UNDERLYING		S A CONSEOU	ENCE OF):		eleste.	nV			5 day	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	S A CONSEOU	ENCE OF):		MASIA	nV			5 day	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	S A CONSEQU	ENCE OF): ENCE OF):			Part I. 24a. WAS AN		24b, W	5 day	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQU	ENCE OF): ENCE OF):			Part I. 24a. WAS AN PERFOR	MED?	AN	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQU	ENCE OF): ENCE OF):			Part I. 24a. WAS AN	MED?	AN CC OI	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant conditions	DUE TO (OR AS	S A CONSEQU	ENCE OF): ENCE OF): HENCE OF):	the underlying	cause given in	Part I. 24a. WAS AN PERFOR	MED?	AN CC OI	MILABLE PRIOR TO OMPLETION OF CAUSE	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQUENT NO PROPERTY OF DEATH	ENCE OF): ENCE OF): Builting in t	the underlying		Part I. 24a. WAS AN PERFOR	MED?	AN CC OI	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant conditiona LITURAL DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS	S A CONSEQUENT DUT NOT TORS	ENCE OF): ENCE OF): HUITING In t H YES OF DEATH (the underlying NO (Check only one)	cause given in	Part I. 24a. WAS AN PERFOR	MED?	AN CC OI	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant conditiona LITURAL DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS	OF DEATH 26. PLACE	ENCE OF): ENCE OF): HUITING In t H YES OF DEATH (O 4	the underlying NO (Check only one) THER: Nursing Home	UNCERTAIN	Part I. 24a. WAS AN PERFOR 1 U YES 2	MED?	AM CC OI	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditiona LILLIAN DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MANNER OF DEATH 1 Ventural 5 Pending	DUE TO (OR AS	S A CONSEQUENT OF DEATH 26. PLACE Purpetlent 3	ENCE OF): ENCE OF): HUITING In t H YES OF DEATH (the underlying NO (Check only one) THER: Nursing Home WOR	UNCERTAIN 5 G Raeldenca	Part I. 24a. WAS AN PERFOR	MED?	AM CC OI	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions LITULAL DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MANNER OF DEATH 1 Tetural 5 Pending Investigation	DUE TO (OR AS DUE TO (OR AS CONTributing to death LULLL BUTE TO CAUSE HOSPITAL: Impetient 2 = ER/Or (Month, Dey, Year	OF DEATH 26. PLACE	H YES OF DEATH (DOA 4 28b. TIME OF INJURY	Check only one) THER: Nursing Home WOR M 1 YI	UNCERTAIN 5 G Residence	Part I. 24a. WAS AN PERFOR 1 YES 2 N S Other (Specify) 28d. DESCRIBE HOW II	NO NO	AN CC OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO	
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditiona LITTLE CONTROLL DID TOBACCO USE CONTROLL EXAMINER? 1 YES 2 700 27. MANNER OF DEATH 1 Natural 5 Pending	DUE TO (OR AS DUE TO (OR AS CONTRIBUTING TO CAUSE HOSPITAL: 1	OF DEATH 26. PLACE PLACE OF DEATH 27 11 11 11 11 11 11 11 11 11	H YES OF DEATH (DOA 10 DOA	Check only one) THER: Nursing Home WOR M 1 YI	UNCERTAIN 5 G Raeldenca	Part I. 24a. WAS AN PERFOR 1 U YES 2	NO NO	AN CC OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO	
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	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) RAY FRANKI 4. SOCIAL SECURITY NUMBER 220-16-3815 9a. FACILITY NAME (If not institution, give str WASHINGTON COUNT RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND 10b. COUNTY MARYLAND 10b. COUNTY MARYLAND 10b. COUNTY 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUC (Specify only highest grade of the county of	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 220-16-3815 9a. FACILITY NAME (If not Institution, give street and number) WASHINGTON COUNTY HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND WASHINGTON 10c. STREET AND NUMBER 5607 RED HILL ROAD 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 17. FATHER'S NAME (First, Middle, Last) JAMES WESLEY WHIPP 19a. INFORMANT'S NAME (Type/Print) FIORENCE V. WHIPP 20a. METHOD OF DISPOSITION 1B Burfal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF UNERAL SERVICE L'ENSEE PA 23. PART I. Enter the diseases, or complications that cau shock, or haart failure. List only one cause or immediate cause or condition	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 220-16-3815 1 X M 2 F 77 9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND WASHINGTON 10c. STREET AND NUMBER 5607 RED HILL ROAD 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES, GIVE WAR OR DATES WORLD WAR II 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 17. FATHER'S NAME (First, Middle, Last) JAMES WESLEY WHIPP 19a. INFORMANT'S NAME (First, Middle, Last) TAMES WESLEY WHIPP 19a. INFORMANT'S NAME (First, Middle, Last) JAMES WESLEY WHIPP 20b. PLACE AN COMMETTED STATE 20b. PLACE AN COMMETTED STATE 20b. PLACE AN COMMETTED STATE 20b. PLACE AN COMMETTED, CROMETER, CR	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 220-16-3815 1	1. DECEDENT'S NAME (First, Middle, Last) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 220-16-3815 1 X M 2 F 77 YRS. 9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND WASHINGTON WASHINGTON WASHINGTON KEEDYS 10c. CITY, TOWN OR LOCAT KEEDYS 10d. STREET AND NUMBER 5607 RED HILL ROAD 11. MARITAL STATUS 1 Never Merried 2 Married 1 Never	1. DECEDENT'S NAME (First, Middle, Last) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 5. SEX 220-16-3815 1	1. DECEDENT'S NAME (First, Middle, Leat) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 2. S. SEX 2. DATE OF DEATH MONTHS ON PROJECT OF DEATH MONTHS ON HOUR	1. DECEDENT'S NAME (First, Middle, Last) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 5. SEX 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 77 YRS. 220-16-3815 1 M 2 2 F 10 M 2 F 10 M 2 M 2 M 1 M 2 M 2	1. DECEDENT'S NAME (First, Middin, Last) RAY FRANKLIN WHIPP 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yr. last birthday) FUNDER 1 YEAR FUNDER 14 YEAR	

Keedy Sville, Md

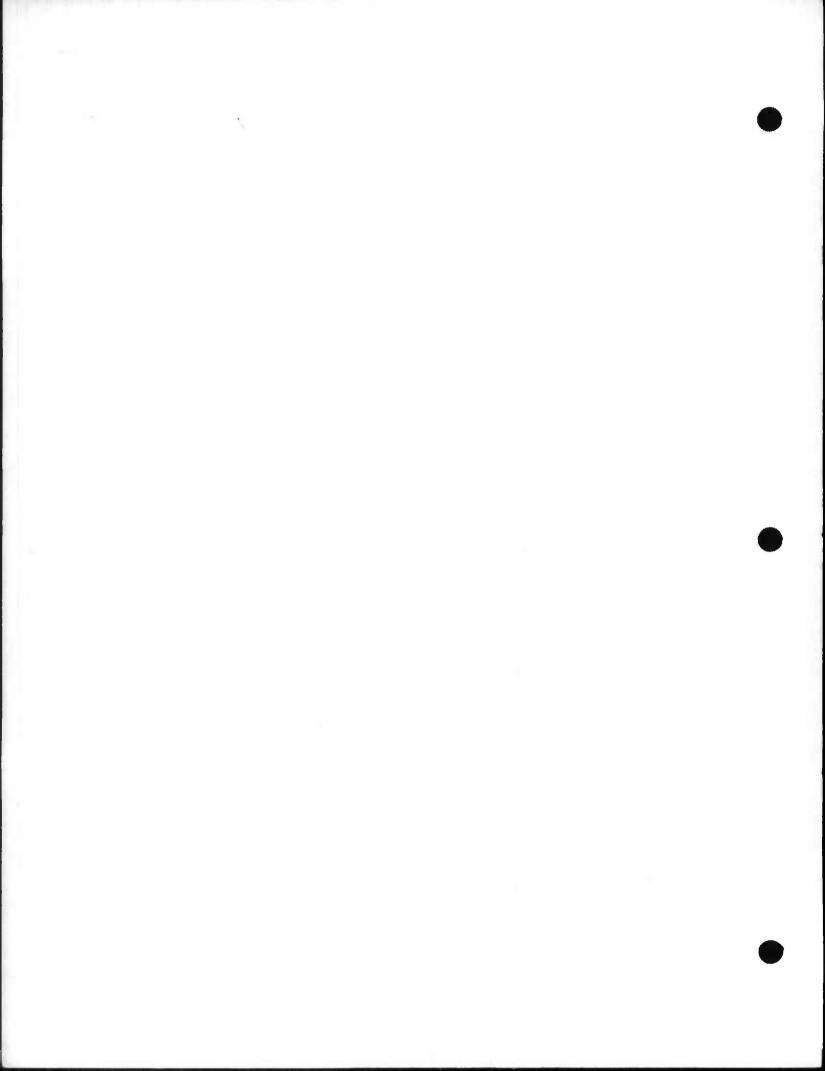
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be ratained by the hospital or atte	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a	hou	IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
PITAL	RAL	27	E 11
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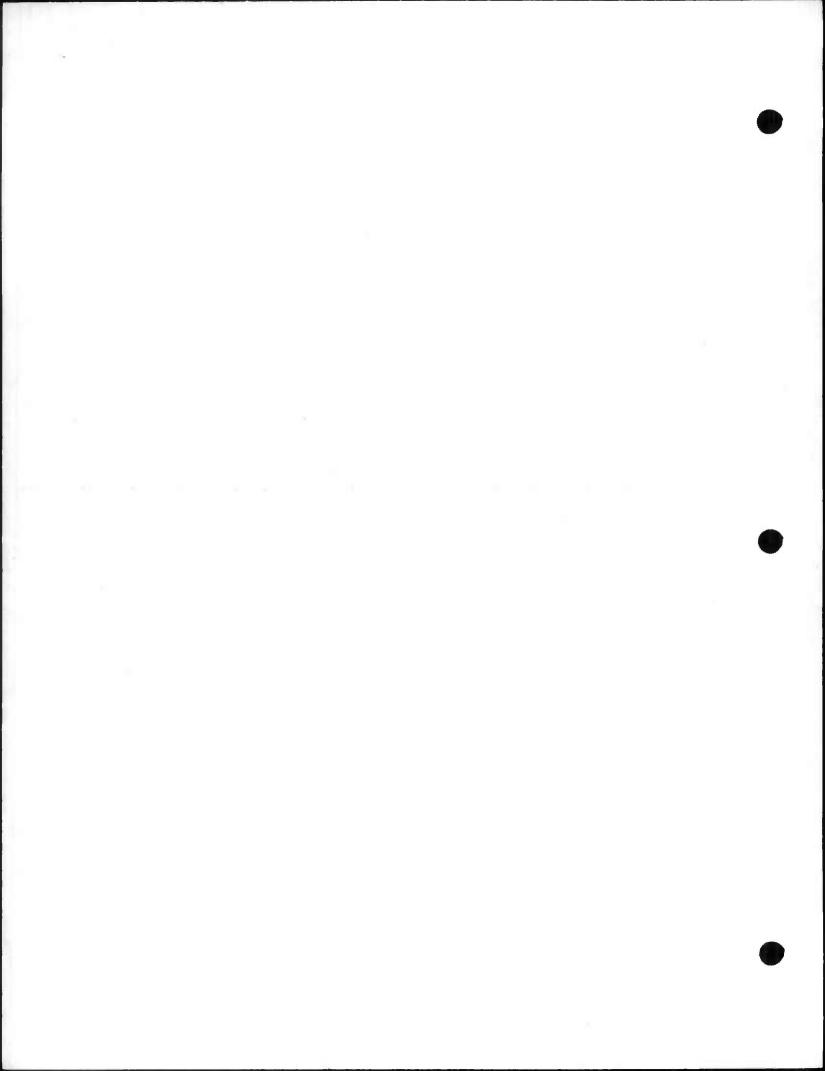
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			NTAL HYGIEN	E		
		WALLACE OCTOBER 3						S 12:50p m	
	4. SOCIAL SECURITY NUMBER 220-48-6825	1 □ M 2 🖾 F 39		UNDER 1 YEAR ITHS DAYS	HOURS MIN.	DATE OF BIRTH (Month, Day, Year) Ctober 1,	1956	BIRTHPLACE (State or Foreign Country) Maryland	
OR	Washington County	Washington County Hospital			DR LOCATION OF DEATH	1	9c. COUNTY		
DIRECTOR	10a. STATE 10b. COUNT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN CO			TION			10d. INSIDE CITY	
	Maryland Washi	ngton	Hage	rstown	. ZIP CODE		10g. CITIZEN	1 TYES 2 NO	
FUNERAL	19735 Meadowbroo				21742		U.S	.A.	
B	11. MARITAL STATUS 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DA	2 XNO	If yea, sp	ENDENT OF HISPANIC (eclfy Cuban, Mexican, P 2 NO Specify:	ORIGIN? (Specify Yea uarlo Rican, etc.)	or No- 14.	RACE — American Indien, Black, White, atc. Specify: White	
ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during mo	ON st of working	16b. KIND OF BUS	INESS/INDUS		
COMPL	17. FATHER'S NAME (First, Middle, Lest)	years	Teacher		40 4405115010 41440	Board o		ation	
BE CO	Ralph Edward Wa	allace			18. MOTHER'S NAME. Dorothy	(First, Middle, Maiden		ffenberger	
0	190. INFORMANT'S NAME (Type/Print) Ralph Edward Walla				nd Number or Rural Rout		, State, Zip Co	de)	
	20a. METHOD OF DISPOSITION	20h	PLACE AND DATE OF DE	SPOSITION/No	me of	DATE 200 LO	CATION CIN	ryland 21742	
	1 1 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	RO	ose HiII Ce	emetery	October2	6,1995 I	lagers	town, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	SENSEE .		22. NAME AN	as A. Fier	TY			
-	23. PART I. Enter the diseases, or	admplications that ceused	the death. Do not e	1331 I	Eastern Bl	vd. North	Hage	rstown Md 21742	
	IMMEDIATE CAUSE (Final disease or condition	Diahe	ech line.	nol	litus.	tup	PT	interval Batween Onset and Death	
	resulting in cleath)	DUE TO (OR AS A	CONSEQUENCE OF):	1 1	21 /	.)		Sugr	
2	Sequentially list conditions, if any, leading to immediate	BUE TO (OR AS A	CONSEQUENCE OF):	u L	sleed,	ng		1 Week	
HILICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	a Deptio	CONSEQUENCE OF):		I weel				
CERT	that initiated events recuiting in deeth) LAST	Diabetes	5 Me	Uit	15/13/	se T		30gr	
ا کا ا	PART II. Other significant, condition	14				PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
MEDIC	Chronic Immu	nosperess	ion Pot 1	Kidner	transp	lant YES 2	THO	OMPLETION OF CAUSE OF DEATH?	
		RIDOTE TO CAUSE O	DEATH ILJ	7 140	UNCERTAIN				
PHYSICIAN:	25. WAS CASE FIEFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		HER:	5 Residence 8	Other (County)			
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJ		d. DESCRIBE HOW IN	JURY OCCUR	ED	
2	2 Accident Investigation	28e. PLACE OF INJURY	- At home, farm, street		ES 2 NO 28	I. LOCATION (Street a	nd Number or I	Pural Route Number	
PLE I EU	4 Homickie 8 Could not be determined	ily)			City or Town, State)		tales roots remain,		
JMPL		CIAN: To the best of my knowl						ause(a) and menner as stated.	
מו כ	SE SHENATURE AND TITLE OF CERTIFIES				29c. LICENSE NUMBER		29d. DATE SI		
	30. NAME AND ADDRESS OF PERSON WH	6 COMPLETED CAUSE OF THE	MD D	9	1)355	17	> /	123/95	
	Dr. Steven Lippma	n 11110 medic	cal Campus		Hagerstown	n, Maryla	nd 21	740	
	31.80 The 8 1995" Jal	REGISTRAR DIGN	TURE						



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

							JP DEAL		REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		3	. TIME OF DEATH
		Jordan Har	man Ye	rkes				k	October 19		YEAR	2:15 p M
		4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. les	t birthday)	IF UNDER 1 Y	AR IF UNDER		7. DATE OF BIRTH			
		216 01 4600	1 🖾 M 2 🗆 F		YRS.		YS HOURS	MIN.	(Month, Day, Year)	,	Country)	ACE (State or Foreign
P		216 - 01 - 4600		94	THS.				October 5	1901	Mar	yland
3 should		9a. FACILITY NAME (If not institution, give	street and number)			9b. CFTY, TO	WN OR LOCATIO	ON OF DEA	TH	9c. COUNT	Y OF DEA	TH
	H H	Calvert Manor Hea	1th Care C	enter			Rising	o S111	1	Co	cil	
1, 2.	CTO	RESIDENCE OF DECEDENT		CHUCI			KISIN	6 541	.1	CE	CII	
Pages	Ĭ,	10s. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OR L	OCATION	_			10	Od. INSIDE CITY
2	DIRE	Maryland	Cecil			Diain	~ C					LIMITS?
permit.	5	10e. STREET AND NUMBER	CECTI		L	KISII	g Sun				1	YES 2 X NO
	ĭ.						10f. ZIP CODE	Ē		10g. CITIZE	N OF WN	AT COUNTRY?
020 physician. burial-transit	FUNERA	1881 Telegraph Ro	ad					2191	11	Uni	ted !	States
020 physician. burial-trar	5	11. MARITAL STATUS	12. WAS DECEDENT EX	VER IN U.S. AR	MED	13. WAS	DECEMBENT OF		C ORIGIN? (Specify Yes			- American Indian,
Duria Duria		1 Never Married 2 Married	FORCES? 1	YES 2 X N		If ye	s, specify Cubar	n, Mexican,	Puerto Rican, etc.)	OF NO.	Black, V	- American Indian, Vhita, atc.
ing the	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 []	YES 2 X NO	Specify:			Specify:	White
215-0 attending se as the	ED									!		
use use	쁘	15. DECEDENT'S EDL (Specify only highest grade				USUAL OCCU	PATION g most of working	ia.	16b. KIND OF BUS	SINESS/INDU	STRY	
Z al or	H	Elementary/Secondary (0-12)	College (1-4 or 5+)	lite.	Do NOT us	e retired.)						
hospital ached for ce.	릴	12		Tra	in Ma	aster			Rail Ro	ad		
AND the hospit detached once.	COMP	17. FATHER'S NAME (First, Middle, Last)					to MOTH	AED'O MAIA	E (First, Middle, Maiden			
be det							1112			Surname)		
2 2 2	H	Clinton Yerkes					V11	rgini	la Taylor			
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burlal notified at once.	2	19a. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS (St	eet and Number	or Rural Ro	oute Number, City or Town	n, State, Zip C	ode)	
	Ĕ	Marsha Knowles		1	833 1	Brubak	er Run	Road	l, Lancast	er P	Δ 176	503
ay be		20s. METHOD OF DISPOSITION						Roac				
BALLIMORE, ter death. Page 6 may be the funeral director, page red.		1 1 Buriel 2 ☐ Cremation 3 ☐ Rem	ioval from State	motery crei	matory or of	F DISPOSITIO				CATION — CI		
age 6 m director.		4 Donation 6 Other (Special	/	North	East	Metho	odist C	Cem.	10/21 Nor	th Ea	st, 1	Maryland
ALIIM death. Page e funeral direc d.		21. SIGNATURE OF FUHERAL BERVIOE LI	plopts /			22. NAM	e AND ADDRES	S OF FACE	ЦТУ			
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rs after on by the removal.		23. PART i. Enter the diseases, or	complications that ca	used tha de	ath. Do n	ot anter the	mode of dvir	ng, such	as cardled or respi	ratory arres	et	Approximate
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Hely atti		disease or condition resulting in death)	. (7)	2.6	VO.							1 Harr
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and and math	ō	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
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th certificate be tending physician all Hygiene prior to other traus	O	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	cDUE TO (OR				lying cause gi	lven in P	art I, 24e, WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
It the death certificate be by the attending physician and Mental Hygiene prior to injury, or other traus.	O	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cOUE TO (OR d	ith but not re			ying cause g	lven in P	art I. 24a. WAS AN PERFOR		AV	AILABLE PRIOR TO
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

VSICIAN: The law requires that the death certificate be executed within 74 hours after death, Page 6 may be retained by the hospital or attending physician,	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dent of Health and Marial Hydiene prior to burial, cemariting, or removal	natic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after d	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filled within 72 hours after death with the State Dent of Health and Mental Hodiene ordor to burial, cremation, or comman	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIEN
	CERTIFICATE	OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR	TMENT	OF H	EALTH DEA	AND		HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH	_
	Helen	Stan1ey			ANGEI	OS			Novem		13.	1995	10:20	D _M
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. In:		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH			PLACE (State or Foreign	n
	219-10-1564	1 M 2 K F	70 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 8-20-1925				Maryland							
œ	9e. FACILITY NAME (If not institution, give s		_				R LOCATI		EATH		9c. CO	UNTY OF D	EATH	
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DIRECTOR						R LOCAT	ION	_					10d. INSIDE CITY	_
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BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES			1 YES	2 ₹ NO	Specif	fy:			Speci	White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	CEDENT'S	USUAL O	CCUPATIO	N et of worki	200	16b. K	ND OF BU	SINESS/IN	DUSTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	MA	. Do NOT u	se retired.)	soring mo	St OF WORK	's						
MP	12			Owne	r					Resta		it		
	17. FATHER'S NAME (First, Middle, Last) Stanley	Card	ians				18. MOT		oebe		Surname)			
BE	19e. INFORMANT'S NAME (Type/Print)	card		h MAH INC	ADDRESS	///			Route Number,					_
2	Peter W. Angelo	S	1		me A			or Hurai	rioute Number,	City or low	n, State, Z	ip Code)		
	20a, METHOD OF DISPOSITION	-	20b. PLACE					_	DATE	20c. LC	CATION -	- City or To	wn. State	
	1 Buriel 2 Cremetion 3 Rem	oval from State	Oak I					1-16	1				ryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	THE STATE OF THE S			22.	NAME AN	D ADDRE	SS OF FA	CILITY					
	W allae	e CB	rock	1.2					unera				2.4	
	23. PART I. Enter the diseases, pr	complications that c	sused the de	ath. Do r	not enter	the mo	ds of dy	Ing, auc	h as cardis	OF resp	Iretory a	reat,	Approximate	
	ahock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one cause	on each line).									Onset and De	
	disease or condition resulting in death)	Coronary	artery	/ dis	ease								9 days	
İ		DUE TO (O	R AS A CONSE	OUENCE O	F):									
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띮	CAUSE (Disease or injury that initiated events	OUE TO (OI	R AS A CONSE	DUENCE O	F):								-	
CERTIFICATION	resulting in death) LAST	d												
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. death. Page 6 may be retained by the hospital or attending physician.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIENE REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Last)	ROSA	ATER:			2. DATE OF DEATH DAY	199r	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 219-32-1027	1 □ M 2XX F 9	n yrs. last birthday) 2 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 1/25/03	V I I	RGINIA	
TOR	96. FACILITY NAME (If not institution, give steem NORTH WEST HOSPIT				ALLSTOWN		BALTII		
DIRECTOR	100. STATE 100. COUNTY MARYLAND BALTI			ETHORPE	ION	10	10d. INSIDE CITY LIMITS? 1 VES 2 X NO		
FUNERAL	100. STREET AND NUMBER 4514 SPRING AVEN				21227		10g. CITIZEN OF V		
BY FUN	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO		cify Cuban, Mexico	NIC ORIGIN? (Specify Yea o an, Puerto Rican, etc.) fy:	Blac	E — American Indian, k, White, etc. ///: BLACK	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of v life. Do NOT us		on st of working	16b. KIND OF BUSI			
MPI	12	0	BEAL	TICIAN			Y SALON	10000	
	17. FATNER'S NAME (First, Middle, Last)					AME (First, Middle, Malden S	umame)		
BE	PRESTON FLOWERS 190. INFORMANT'S NAME (Type/Print)		I 405 MAII INC	ADDRESS (Street o	WILLIE	BRUWN Route Number, City or Town,	Crata Pla Cadal		
2	RUTH RIVERS					IMORE, MARYL		15	
	20a, METHOD OF DISPOSITION	206	PLACE AND DATE				ATION — City or To		
	1 X Buriel 2 Cremation 3 Remo		RYLAND"			/13/95 LAU	IREL, MAR	YLAND	
	21, SIGNATURE OF FUNERAL SERVICE LIC			22. NAME AN	D ADDRESS OF F				
	* Toul	1 Pati	20			ACE BALTIMO		AND 21217	
	23. PART I. Britar the diseases, or o							Approximate	
	immediate cause (Final disease or condition resulting in death)	Liat only ona cause on a OBSTRU	CTIVE	JAUN	DICE			Interval Between Onset and Death Face	
		DUE TO (OR AS A	CONSEQUENCE OF	F):					
N O	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):								
ERTIFICATION	if sny, lasding to immediata cause. Enter UNDERLYING	-		r					
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ERT	resulting in death) LAST	d,							
2	PART ii. Other algnificant condition	s contributing to death b	ut not resulting	in the undarlyin	g csuse givan ir			b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
CA		PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 JANO							
MEDICA								OF DEATH?	
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S NO C	UNCERTA	IN E			
SIA	25. WAS CASE REFERRED TO MEDICAL.		26. PLACE OF DEA						
SIC	1 VES 2 NO	HOSPITAL: 1 Inpetiant 2 I ER/Outs	petient 3 🗆 DOA	OTHER:	ne 5 🗆 Realdenca	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Yeer)	26b. TIM	JURY WO	IURY AT ORK?	28d, DESCRIBE HOW IN	JURY OCCURED		
ВУ	1 Accident 5 Pending Investigation				YES 2 NO				
	3 Suicide 6 Could not be determined 286. PLACE OF INJURY — Al home, ferm, street, factory, office building, etc. (Specify) 286. LOCATION (Street and Number or Rural Route Number, City or Town, Stele)								
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beet of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beets of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(a) and manner as steted.								
BE C	290. DENATURE AND TITLE OF CERTIFIE	'o			290 LICENSE NU	JMBER		D (Month, Day, Yeer)	
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	31. DATE EXEO (Month, Day, Year)	3. REGISTRAR'S GIGN	ATURE						
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

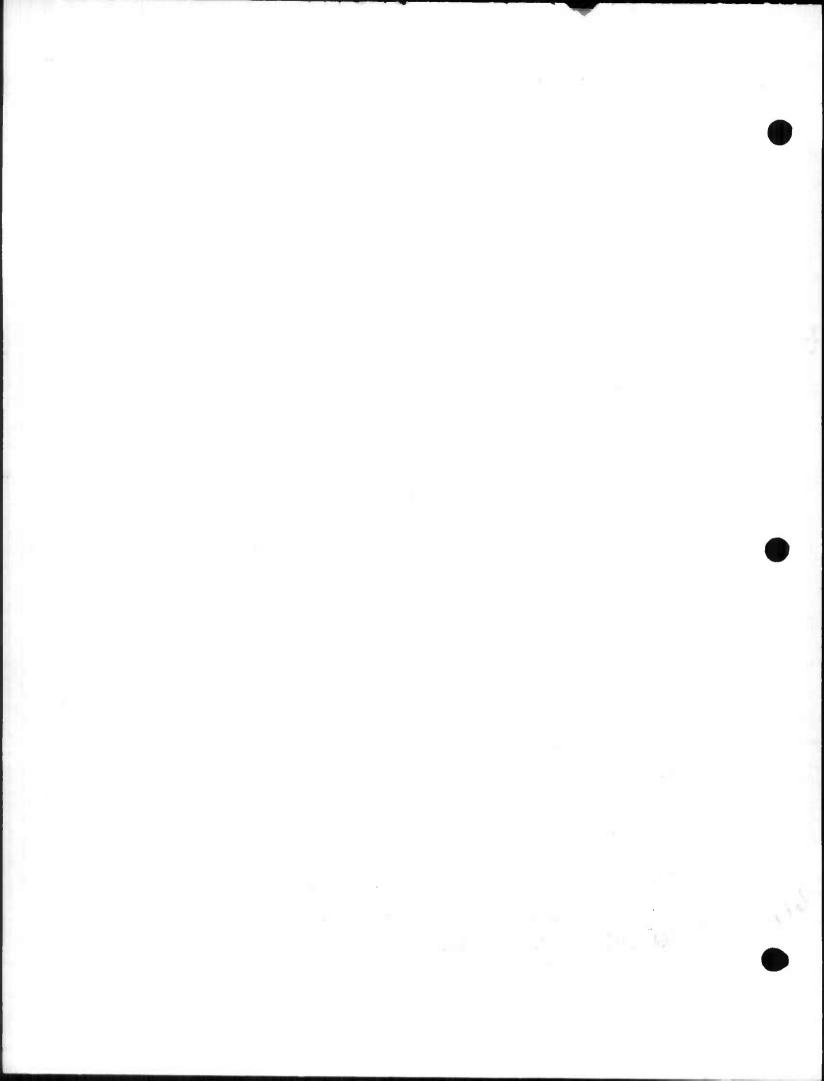
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.								
	MONTH , DAY YEAR	OF DEATH							
	100 17 1945 4	1 P M							
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Country) 8. BIRTHPLACE (Str. Country)	ste or Foreign							
	206-10-1245 1 M 2 F 78 YRS. 8-10-17 PENNSYL	.VANIA							
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
OH	HOPKINS BAY VIEW BALTIMORE N7A								
DIRECTOR	RESIDENCE OF DECEDENT	DE CITY							
E	MARYLAND BALTO. CO. BALTIMORE 1 VES	TS?							
FUNERAL	7814 E. COLLINGHAM APT B 21222 USA								
N N	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No — 14. RACE — Americ FORCES? 1 Yes 2 No If yee, specify Cuben, Mexican, Puerto Ricen, etc.)	cen Indien,							
E	FORCES? 1 X YES 2 NO If yes, specify Cubsn, Mexican, Puerto Ricen, etc.) If yes, specify Cubsn, Mexican, Puerto Ricen, etc.) Black, White, at 1 YES 2 NO Specify: Specify:	ic.							
В	3 Wildowed 4 Divorced ARMY -1951 WHITE								
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working								
9	Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.)								
MPI	12 YEARS ELECTIRCIAN GLIDDEN CO.								
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname)								
BE	LUUIS ALEX MARY RUVANSKY								
0	198. INFOHMANT 5 NAME (type/Print)								
	THOS. MICHELLE ALLA								
	20s. METHOD OF DISPOSITION 20s. METHOD OF DISPOSITION 20s. DESCRIPTION (Name of 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,							
	4 Donation 6 Other (Specify) SACRED HEART OF JESUS CEM. BALTO., CO. ME	, .							
	1201 DUNDALK AVENUE BALTO, MD.	21222							
(Challes R. Xelselaush								
		proximata erval Between							
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	disease or condition resulting in death) a. Duft To (or as a consequence of):	unutes.							
	DUE TO (OR AS A CONSEQUENCE OF):								
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ATI	If any, leading to immediate cause, Enter UNDERLYING								
FIC.	CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):								
E	thet initiated events resulting in deeth) LAST								
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PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER:								
YSI	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)								
PH	27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 1 Natural 5 Pending 280. DATE OF INJURY WORK? 1 Natural 5 Pending								
B	2 Accident Investigation								
		ber,							
ETE	4 Numera Gotellines								
29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.									
COMPLETED	2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occurad at the time, date and piece, and due to the ceuse(s) and man	iner as stated.							
ш	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D	lay, Year)							
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	JOHN ROOTY MD BAYNEWING) CENTER, CAUTERN AVE BAY	- MD							
	32 REGISTRAR'S SIGNATURE								

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shoul	_	9e. FACILITY NAME (If not institution, give	street end number)				9b. C
2, 3	DIRECTOR	Good Samaritan	Hospital				
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ermit	4	10e. STREET AND NUMBER	,			<u> </u>	
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death. Pag e funeral dir ii. examiner		N. Muss	(111.0				
rs after d by the removal.	_	23. PART I. Enter the disembs, o	r complications th	at chuse	d the de	eth. Do	not en
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within 24 hou mpletely filled i cremation, or went, the m		IMMEDIATE CAUSE (Final disease or condition	(11	205	i = i	201	C
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he death certificate be execute the attending physician and or Mental Hygiene prior to bunia njury, or other traumatic	2	CAUSE (Disease or Injury		O (OR AS			
ding ding lygien	Ĭ.	that initiated events resulting in death) LAST	302	can no) c	CONSEC	O ENGE C	n- j.
attendi	CE		d				
and the and Me	AL	PART II. Other aignificant condit					
equires that the death certificate be executed within 24 hours after death. Page en signed by the attending physician and completely filled in by the funeral direct of Health and Mental Hygiene prior to bunal, cremation, or removal. Ihows any injury, or other traumatic event, the medical examiner in the medical examiner in the medical examiner.	MEDICAL CERTIFICATION	CONGESTIV	E HEA	FRT	7	AT	LU
- 0 00		DID TOBACCO USE CON	ITPIRITE TO C	ALICE C	DE DE A	TH V	ES [
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SICIA certif h the	PHY:	27. MANNER OF DEATH	28e. DATE O	F INJURY		28b. TII	AE OF
NG PHYSI fter this c eath with marked,		1 Natural 5 Pending		Day, Year)		I IN	JURY
NDING F R. After 1 r death is mar	D BY	2 Accident Investigated 3 Suicide 8 Could not	28e. PLACE	OF INJURY	f At ho	me, ferm,	atreel,
afte 82	TE	4 Homicide determined		, 5.5. (0)0			
PH DIR	PLE	29e. CERTIFIER (Check only	YSICIAN: To the best of	of my knov	vledge, de	ath occur	red at I
HOSPITAL FUNERAL WITHIN 72	COMPLETED	ane)	INER: On the bests of	examinatio	on end/or l	investigati	on, In r
THE HOSPITAL THE FUNERAL filed within 72 I	ш	296. SIGNATURE AND TITLE OF CERTIF	FIER	11 -	_		
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95 7. DATE OF BIRTH (Month, Day, Year) Sept. 9, IDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1897 Massachusetts CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore N/A N OR LOCATION 10d. INSIDE CITY 1 X YES 2 NO altimore 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21209 USA 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, P.

1 YES 2 NO Specify: White L OCCUPATION one during most of working ed.) 18b. KIND OF BUSINESS/INDUSTRY Chocolate Factory cer 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lilly Casey RESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) en Oak Rd., Baltimore, MD 21209 POSITION (Name of 20c. LOCATION -- City or Town, State DATE Everett, MA 22. NAME AND AODRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214 ter the mode of dying, auch as cardiec or respiratory arrest, Approximate Interval Between Onset and Death DAYS ACI DOSIS MOWITS URE MONHYS 24a. WAS AN AUTOPSY PERFORMED? underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? RE 1 YES 2 M NO 1 | YES 2 | NO □ NO □ UNCERTAIN □ eck only one) Nursing Home 5 - Residence 8 - Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO factory, office 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) the time, date end piece, end due to the cause(s) end menner es stated. my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner es stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 95 D47014 NOV 15. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HOSPITAL A. JANECKI JOHNS HOPKINS 31. DATE FILED (Month, Day, NOV 16 REGISTRARYS SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	pes 1, 2		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF					ENTAL	HYGIENE REG. NO.			
t. DECEDENT'S NAME (First, Middle, Last)							2. DATE O	F DEATH			TIME OF DEATH
GEORGE T. BROWN							11	1		95	10:00 Am
4. SOCIAL SECURITY NUMBER 212-03-2733		yrs. lest birthday)	IF UNDER	1 YEAR DAYS	HOURS 24	4 HRS.	7. DATE O	F BIRTH Day, Yesr))1-1906	6	Country) MARYL	ACE (State or Foreign
9e. FACILITY NAME (If not institution, give	, , , , , , , , , , , , , , , , , , ,	8 YRS.	9h CITY	TOWN	R LOCATION	A OF DEA		11-190	9c. COUNT		
HOME 9 GORMAN AV			30. 0111		TIMOR					TIMOF	
RESIDENCE OF DECEDENT									DAL		
MARYLAND BAL	_TIMORE	10c. CIT	Y, TOWN O	LTIM							d. INSIDE CITY LIMITS? XYES 2 NO
10e. STREET AND NUMBER	TITIONE		חט		ZIP CODE				10g. CITIZE		T COUNTRY?
9 GORMAN AVENUE	-				21223	3				U.S.A	<i>A</i> .
11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER IN 1 FORCES? 1 X YES IF YES, GIVE WAR OR DAT	2 NO		If yes, spe	ENDENT OF celfy Cuben, 2 X NO	Mexican,		(Specify Yes o	r No- 1	4. RACE — Black, W Specify:	American Indian, Inite, etc. BLACK
3 X Wildowed 4 Divorced							1				
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Elementary/Secondary (0-12)	College (1-4 or 5 +)	TRUCK	DRI	VER				BENI	XIC		
17. FATHER'S NAME (First, Middle, Last)								ddle, Meiden S			
JOHN THOMAS								BROW			
FLORENCE BROWN								r, City or Town, RE, MAR!			23
20s. METHOD OF DISPOSITION 1		RISON F				RY 11	0ATE		TNGS		MARYLAND
21. SIGNATURE OF FUNERAL SERVICE L								IERAL I		11266	, mart Eravo
Lloy 1	7. Cale		1	300	EUTAW	I PLA	ACE B	ALTIM(DRE, M		AND 21217
23. PART I. Enter the diseases, or ehock, or heart feiture.	complications the caused. List only one cause on ea	the death. Do i ch line.	not enter	the mo	de of dyin	g, auch	as cardi	ac or respire	lory arres	st,	Approximate Intervei Between
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	b.										
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):								
CAUSE (Disease or Injury	c. DUE TO (OR AS A C	CONSEQUENCE O	Fi:								
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PART II. Other significant condition) cause gi	ven in P	art i.	24s. WAS AN A PERFORM		AN	ERE AUTOPSY FINDINGS WILABLE PRIOR TO DMPLETION OF CAUSE
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27. MANNER OF OEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM	ME OF JURY M	28c. INJI WO	RK?		26d. DE\$0	CRIBE HOW IN	JURY OCCU	RED	
2 Accident Investigation 3 Suicide & Could not be	2 Accident Investigation 26s. PLACE OF INJURY — At home, farm, street, factory, office 281, OCATION (Street and Number or Bural Boute Number						le Number,				
4 Homicide 6 Could not be determined	building, etc. (Specif	(y)						r Town, State)			
29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFI	ER /UMM	0			29c. LICEN	S13	SEB-		29d. DATE	SIGNEO (M	onth. Day. Year) 10, 1995
30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEAD	TH (ITEM 27) (Type	Brine)	VADU	UM	BK	nn	NURG	MD	21	
31. DATE FILED (Month, Pay, Year) NOV 1 6 1995	32 REGISTRAR'S GNA								1		

• 0 (a)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 **DIVISION OF VITAL RECORDS, P.O. BOX 68760**

FOR 1 . STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	-ICATE	OF DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY	YEAR 3. TIME OF DEATH
	ARMANELLA	KS			11/8/95		11:30 HM	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)		AR IF UNDER 24 HRS.	(Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	214 40 5136		86 YRS.			7/16/09		MARYLAND
	9e. FACILITY NAME (If not institution, give				WN OR LOCATION OF DI	EATH	200	NTY OF DEATH
6		APPLETON ST	REET	BAI	_TIMORE		B	ALTIMORE
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	10c. CI	TY, TOWN OR L	OCATION			10d, INSIDE CITY
E	MARYLAND BALT	IMORE		BALTI	MORE			LIMITS?
	10e. STREET AND NUMBER	2710112		DITETT	101. ZIP CODE		10g. CITI	ZEN OF WHAT COUNTRY?
EB/	1654 NORTH APPL	ETON STREET			21217			U.S.A.
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED		OECENDENT OF HISPAI		or No-	14. RACE — American Indian, Black, White, etc.
BY F	1 Never Manted 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	DATES		s, specify Cuben, Mexico		- 1	Specify: BLACK
				1		T		
	15. DECEDENT'S ED (Specify only highest grad	le completed)	16e. DECEDENT (Give kind o life. Do NOT	I work done durir	PATION ng most of working	16b. KIND OF BU	SINESS/IND	BUSTRY
١ڐ	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		CHER		DIIDI T	c ccn	OOL SYSTEM
COMPLETED	17, FATHER'S NAME (First, Middle, Last)	<u>J</u> T	I IEA	CHER	16. MOTHER'S NA	ME (First, Middle, Maider		OUL SISIEM
Ö	ALFRED HARRIS					LA OUEEN	,	
BE	19e. INFORMANT'S NAME (Type/Print)		19b, MAILIN	IG ADDRESS (S	treet end Number or Rural		vn, State, Zip	Code)
2	RUSSELL L. BANKS		1654	NORTH	APPLETON S	TREET BALT	IMORE	MARYLAND 21217
	20. METHOD OF DISPOSITION		b. PLACE AND DAT	E OF DISPOSITIO				City or Town, Stata
	1X Burlet 2 Cremetion 3 Rei	Novet from State	ESTERN S	TAR CEI	METERY 11/	11/95 CA	TONSV	ILLE MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE			EP BROTHER		HOME	DΛ
	1 Coul C	1.1.0						IARYLAND 21217
	23. PART Nenter the diseases, or							
		List only one cause on	each line.	/				interval Between Onset and Death
	disease or condition							
	reaulting in death)	DUE TO OR AS	A CONSEQUENCE	OF).	1000000			1
z								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE	OFF: N				
CA	ceuse. Enter UNDERLYING CAUSE (Disease or Injury	c						
H	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE	OF):				
Ä		d						
	PART II. Other eignificent condition	ne contributing to deeth	but not regulting	g in the unde	riying ceuse given in	Part I. 24s. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL						1 TES		COMPLETION OF CAUSE DF DEATH?
MED								1 TYES 2 NO
	DID TOBACCO USE CON	TRIBUTE TO CAUSE	OF DEATH	res 🗆 No	UNCERTAL	N 🗆		
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DE		one)			
SIG	1 VES 2 AO	1 Inpetient 2 ER/Ou	rtpatient 3 🖸 DOA	OTHER:	Homa 5 2 Reeldence	6 Other (Specify)	_	
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year,		IME OF 28	c. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OC	CURED
ВУ	1 Neturel 5 Pending 2 Accident Investigation			- M	1 YES 2 NO			
ED E	3 Suicide 8 Could not b	26e. PLACE OF INJUI building, etc. (Sp	RY — At home, fem pecify)	n, atreet, tectory	office	26f. LOCATION (Street City or Town, State	end Number	r or Rural Route Number,
ETE	4 Homicide determined							
IPLI	(Check only	SICIAN: To the best of my kno	owledge, death occu	arred at the time	, date end place, end du	e to the cause(e) end m	nner ee ata	ited.
COMPL	one) 2 MEDICAL EXAMI	NER: On the basis of examinat	ion end/or investigs	tion, in my opir	ion, death occured at th	e time, date end place, e	ind due to the	he ceuse(e) end menner ee stated.
ш	29b. SIGNATURE AND TITLE OF CENTRE	ER			29c, LICENSE NL	JMBER	29d. DAT	TE SIGNED (Month, Day, Year)
TO B	10000	wan MY	7		2163	122	10	1 10 95
F	30. NAME AND ADDRESS OF PERSON V		DEATH (ITEM 27) (Ty	rpe, Print)	1 Com	+101		
	Lywrence	20/0 hon	400	000	& Cour	1 Kd		
	NOV 1 6 1995	32. REGISTRAR'S SIG	A. M					

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	ERTIF	ICATE OF	DEATH		REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) Donald Brooks				MONTH	embe		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 218-36-4795 S. SEX 12 M 2 □ F 54	last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (DE BIRTH Day, Year) -26-41	6.	BIRTHPLACE (State or Foreign Country) aryland
TOR	99. FACILITY NAME (If not institution, give street and number) Sinai Hospital RESIDENCE OF DECEDENT			imore	EATH		9c. COUNTY	
DIRECTOR	10a. STATE 10b. COUNTY N/A	10c, CITY	y, town or locat Balt	imore				10d. INSIDE CITY LIMITS? 1 YES 2 \(\text{\tint{\text{\tint{\text{\tint{\text{\tin\text{\texi}\text{\text{\text{\texit{\tex{\texit{\texi{\texi{\texi{\texi{\texi{\texi{\texi\texi{\texi{\tetit}\texi\titt{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\
FUNERAL	477 Watty Court			21201				OF WHAT COUNTRY?
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S., FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		If yes, sp	ENDENT OF HISPAN scify Cuban, Maxica 2 10 NO Specify	in, Puarto F		r No- 14.	RACE — American Indian, Black, Whita, etc. Specify: Black
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	DECEDENT'S (Give kind of w life. Do NOT us Labor		st of working		Disab	led	
BE CO	17. Father's NAME (First, Middle, Last) Eugene Brooks			18. MOTHER'S NA Beat	ME (First, A	e Bare	ntin	е
TO B	19a. INFORMANT'S NAME (Type/Print) Betty J. Brooks	3580	ADDRESS (Street a	nd Number or Rural I	Route Numb	Heigh	State, Zip Co	Öhio 44120
	Burlai 2 Cremetton 3 Removal from State 4 Donatton 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Zion	22. NAME AI	ery 11/	CILITY	95 Bal	to.,	
	North State CFS	P #28	81 E.L.	Phillip	s F	/H Bal	to.,	MD. 21217
	23. PART I. Enter the diseases, or complications that ceused the ahock, or heert failure. List only one cause on each if iMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS & CONSTITUTE OF TO (OR AS	ine.					itory srreet	Interval Between Onest and Death
CERTIFICATION	disease or condition resulting in death) a. Pneumocystis carini neumonia Due to (or as a consequence of): A DS Due to (or as a consequence of): Leave the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.							
EDICAL	PART II. Other significent conditions contributing to death but no Injection Orang Use	t resulting	resulting in the underlying cause given in Part I.			24a. WAS AN A PERFORM	IED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
PHYSICIAN: M			TH (Check only one)	UNCERTAI	И□			
YSIC	EXAMINER? 1 ☐ YES 2 NO HOSPITAL: 1 Ø Inpetient 2 ☐ ER/Outpetient			na 5 🗆 Raaldence	6 🗆 Othe	r (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Neturni 5 Pending 2 Accident Investigation	28b. TIM INJ		URY AT ORK? YES 2 NO	28d. DES	CRIBE HOW IN	JURY OCCUR	RED
	3 Suicide 4 Homicide 5 Could not be determined 28s. PLACE OF INJURY — At home, term, street, tectory, offica building, etc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)							Rural Route Number,
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: On the basic of examination and							ause(s) and manner as stated.
TO BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	MBER		29d. DATE S	IGNED (Month, Day, Year)
_	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I	ing / l	tospita	1 Ba 17	Timo	re, m	02	1215

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2. DATE OF DEATH

FOR STATE REGISTRAR

DECEDENT'S NAME (Figst, Middle, Last)

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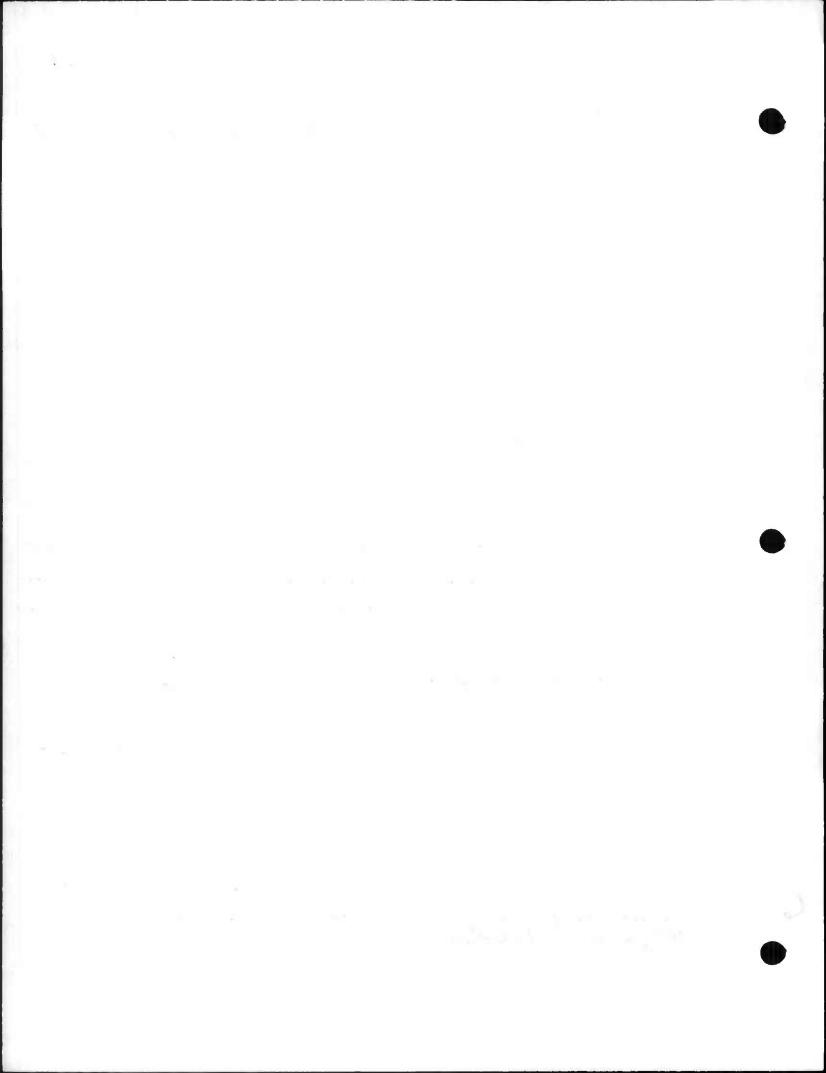
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DIVISION OF VITAL RECORDS,	The second contract of the second contract of
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NoV 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthde IF UNDER I YEAR IF UNDER 24 HRS. 7 DATE OF BIRTH BIRTHPLACE (State or Fo (Month, Day, Year) 9-15-13 DAYS HOURS 214-03-2030 1 M 2 X F 82 MARYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR RITCHIE HOSPICE BALTIMORE N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY MARYLAND N/A BALTIMORE 1 X YES 2 NO permit. 10e, STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? completely filled in by the funeral director, page 5 should be detached for use as the burial-transit rial, cremation, or removal. 2439 FLEET STREET 21224 USA Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE --- American Indian, Black, White, atc. 1 Never Mantled 2 Merried Specify: WHITE BY 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5 +) 8 YEARS HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at THOMAS KREMMER LILLIAN FERGURSON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. RUTH BONNER BLUESTONE ROAD KINGSVILLE. MD.21087 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must 1 Buriel 2 Cremation 3 Remove from State
4 Donetion 5 Other (Specify N D M B M F N) COPARKWOOD PARK M. 11-15 BALTO. CO. MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD 21224 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heart fellure. List only one cause on each line. Approximeta interval Between **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition resulting in death) Myocardial anoxia hour event, 1 DUE TO (OR AS A CONSEQUENCE OF): burial, READ CT (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION calcinoma y car and Sequentially list conditions, Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending physician Mental Hygiene prior to Aortio Stenosis other t DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 5 Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY PERFORMED? signed by the Health and N shows any Diasetes mc/litus t TYES 2 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be 23 25. WAS CASE FIEFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h with the State [HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) Riche. 0 27. MANNER OF DEATH 28s. DATE OF INJURY marked, 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural м 1 YES 2 NO ΒY Investigation After death 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 3 Suicide 6 Could not be COMPLETED DIRECTOR: hours after 28 4 Homicide item 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(e) end manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 13006 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimore Dowell Read mous 101 SIGNATURE DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



ge 6 may be retained by the hospital or attending physician. If the pear 1, 2, 3 should lirector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

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BALTIN	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Pag	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral di	
8/	after d	by the	bours after death with the State Dept. of Health and Mental Hydiene prior to burlal, cremation, or removal.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	nires	signe	Health
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		Item18 11-16	-95 Filmg729 W	.H.per	F/H			95	34598
		FOR STATE REGISTRAR	STATE OF MARYLANI) / DEPAR Certif	TMENT OF	HEALTH AND DEATH	MENTAL HYGIEN	_	
)		1. DECEDENT'S NAME (First, Middle, Leet)	BA	RT Ko	WIAK		2. DATE OF DEATH MONTH D	2 190	3. TIME OF DEATH
모		4. SOCIAL SECURITY NUMBER 213-05-5204	1 □ M 2 以 F	lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 5 - 24 - 07		BIRTHPLACE (State or Foreign Country) ARYLAND
2, 3 should	TOR	99. FACILITY NAME (If not institution, give si GOOD SAMARITAI RESIDENCE OF DECEDENT				BALTIMO		9c. COUNTY	Y OF DEATH
permit, Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY MARYLAND	N/A		Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS? 1 XYES 2 NO
Sit	FUNERAL	100. STREET AND NUMBER 325 HORNEL STRE	EET			01. ZIP CODE 21224		10g. CITIZEI	N OF WHAT COUNTRY?
spital or attending physician. hed for use as the burial-transit	E COMPLETED BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED NO	If yes, s	CENDENT OF HISPA specify Cuben, Mexico S 2 X NO Specific	NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) fy:	B or No.— 14	Black, White, etc. Specify: WHITE
		15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 8 YEARS	Completed) College (1-4 or 5+)	Give kind of ville. Do NOT us	USUAL OCCUPAT work done during m e retired.)	TION nost of working	166. KIND OF BU		TRY
by the hospital be detached for all once.		17. FATHER'S NAME (First, Middle, Last) JOSEPH RESNER		OFILMA	NLIV	18. MOTHER'S NA	ME (First, Middle, Meiden	Sumame) Ma	ary Derda VERN, MD. 21
be retained ige 5 should be notified	TO BE	190. INFORMANT'S NAME (Type/Print) mr. john wancov	vicz				Route Number, City or Tow		ode)
e 6 may ector, pa must b	0 0	20e. METHOD Q5 DISPOSITION 1	20b.PLA	CE AND DATE (OF DISPOSITION /A			CATION — City	y or Town, State
death. P tuneral d. examin		Rauls R. X	sproudei		2525	FLEET	FUNERAL ST. BALTO	D. MD.	. 21224
24 hours / filled in the tion, or ref		23. PART I. Enter the diseases, or o shock, or heart fellura. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Schemi	ine.	rdiomy	opathy	th ea cerdlec or reap	ratory arread	t, Approximate interval Between Onset and Death
nd com burial,	CATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	OUE TO (OR AS A CON	Jeotu Jeotu Iseouence of	lary.	lay Hote	y Disease	e	
th certifica tending phy al Hygiene or other	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CON	ISEQUENCE OF	7:				
at the by th and N	MEDICAL	PART II. Other eignificant condition	e contributing to deeth but no Mellitus	ot resulting i	n the underlyin	ng cause given in	Part i. 24s. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N: The law requires icate has been sign State Dept. of Heal item 23 shows	SICIAN: N	DID TOBACCO USE CONTR			S NO [NB		1 YES 2 NO
PHYSICIAN: The law requires the this certificate has been signed with the State Dept. of Health riked, or item 23 shows an	PHYSIC	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	NOSPITAL: 1 Inpatient 2 ER/Outpatient 28e. OATE OF INJURY	3 DOA	OTHER: 4 Nursing Hor E OF 28c. IN	me 5 Residence	6 Other (Specify) 28d. OESCRIBE HOW I	NJURY OCCUF	REO
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate ha bours after death with the State Ditem 28 is marked, or item	ED BY	1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined	(Month, Day, Year) 28e. PLACE OF INJURY — Ai building, etc. (Specify)		M 1 🗆	YES 2 NO	28f. LOCATION (Street City or Town, State)	and Number or	Rural Route Number,
TAL OR TAL DIRI	COMPLET		CIAN: To the best of my knowledge						
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: 11	BE	296. SIGNATURE AND TITLE OF CENTURE ALONG	a: On the beals of exemination end	ror investigation	n, in my opinion,	29c. LICENSE NUI			IGNED (Month, Day, Year) OUCHBER 12th 1995
	임	36. NAME AND ADDRESS OF PERBON WHO	COMPLETED CAUSE OF OFATH (ITEM 270 (Keeps	Drinel				(1/4 1/1

DIPLETED CALISE OF OEATH (ITEM 27) (Typo, Print)

JUNNS MOPYCAS ON COLOGY

22. RECESTRATES SIGNATURE

Certer

BATIMORE

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31. DATE FILEO (Month, Day, 18)
NOV 1

DHMH-18 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	TATE OF MARYLAI	ND / DEPART	+		MENTAL HYGIEN				
1. DECEDENT'S NAME (First, Middle, Last)	1 11				2. DATE OF DEATH MONTH , DAY YEAR 3, TIME OF DEATH				TH
Elizzbeth 13	irkett				November		995 4	4:47	PM
4. SOCIAL SECURITY NUMBER 5. S	, , , , , , , , , , , , , , , , , , , ,	M	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	1000	Country)	ACE (State or F	iorelgn
212-05-8952 1 E		101 YRS.	A CUTY TOWN O	D LOCATION OF DE	December 23		Maryl		
Sinai Hospital	ind number)		Baltimo	OR LOCATION OF DEATH ONE N/A					
RESIDENCE OF DECEDENT									
Maryland Baltimo	ore	10c. CITY, 1	TOWN OR LOCAT	nsville				LIMITS?	
100. STREET AND NUMBER	, i e			101. ZIP CODE 10g. CITIZEN OF W				YES 24	NO NO
							S.A.	KI COONTRY?	
11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U	J.S. ARMED	13, WAS DEC		IIC ORIGIN? (Specify Ye		14. RACE	- American Ind	llen,
I Ideal wellied 5 wellied	FORCES? 1 YES			city Cuban, Mexica 2 XXNO Specify	n, Puerto Rican, etc.)		Black, V Specify:	Vhite, etc.	
3 🔀 Widowed 4 🗌 Divorced	/							White	
15. DECEDENT'S EDUCATIO (Specify only highest grade comp		(Give kind of wor life. Do NOT use i	k done during mo:		16b. KIND OF BL	ISINESS/INC	DUSTRY		
Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	Homema			Own Ho	me			
17. FATHER'S NAME (First, Middle, Last)		HORRAIC	1001	16. MOTNER'S NA	ME (First, Middle, Meide				
Joseph Narer					et Snoops				
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DORESS (Street e	nd Number or Rural i	Route Number, City or To	wn, State, Zip	Code)		
Elizabeth M. Boarman (gr	randdaughter)	3352 I N	Vorth Cha	tham Road	Ellicott Cit	y, Mar	yland	21042	
20e. METHOD OF DISPOSITION 1 To Buriel 2 Cremation 3 Removal		PLACE AND DATE OF					City or Town		
4 Donation 5 Other (Specify)		raine Park				xdlawn,	Maryla	and	
21. SIGNATURE OF PUBLISHED SERVICE LICENSE	1 :10			M. & RUSSE	11 C. Witzke	e Funer	al Hom	25	
Trescesson) colo				venue Cator				228
23. PART I. Enter the diseases, or companock, or heart failure. List			t antar tha mo	da of dying, auc	h as cardiac or rea	olratory an	rest,	Approxin	
IMMEDIATE CAUSE (Final								Onset an	nd Death
disesse or condition resulting in death) a	DUE TO (OR ASA	retion T	Presmo	niz				3-4	grap
	DUE TO (OH AS W	CONSEQUENCE OF):							0
Sequentially liet conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):						†	
cause. Enter UNDERLYING CAUSE (Disease or Injury									
thet initiated events	DUE TO (OR AS A (CONSEQUENCE OF):							
resulting in death) LAST								-	
PART II. Other algnificent conditions co						N AUTOPSY		TERE AUTOPSY	
Hyponstremi		Mellitus			DE 1 YES	1	C	OMPLETION OF F DEATH?	
Demantiz	,		′),			☐ YES 2	(NO
DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	□ NO Œ	UNCERTAI	N				`
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	8. PLACE OF DEATH	(Check only one)						
1 TYES 2 X NO	Inpetient 2 - ER/Outpe	tlent 3 DOA 4	Nursing Nor		6 Other (Specify)				
27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY WO	PRK?	26d. DESCRIBE NOW	INJURY OC	CURED		
2 Accident Investigation	26e. PLACE OF INJURY -	- At home, farm, etc			28f. LOCATION (Stree	t and Numbe	r or Rural Bou	ite Number.	
3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specif	y)			City or Town, Stat				
29a. CERTIFIER 1 X CERTIFYING PHYSICIAN	: To the best of my knowle	doe death occurred	at the time, date	and place, and due	to the cause/s) and m	anner as sta	ted.		
(Check only one) 2 MEDICAL EXAMINER: O					EE M. B. G. G. C.			end menner es	ateted.
296. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NU	MBER	29d, DAT	TE SIGNED (A	fonth, Day, Yea	r)
1 the what	MD			ASZ4023	21-54-9920	D N	lovembe.	11, 19	795
30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA					ža.		1	
Stephen Hertzell, Sinz	i Hospital of	- Beltimo	re. 2401	. Belveder	e Alenve, Be	Himore	Mery	Isnd	
NOV 1 6 1995	32 REGISTRAR'S CHA	EX							

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	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTI			MENTAL HYGIE REG. N				
	1. DECEDENT'S NAME (First, Middle, Last)	BUTLER				2. DATE OF DEATH MONTH	13 9	3. TIME OF DEATH		
	210 07 4170	5. SEX 6. AGE (In yrs 1 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		IF UNDER 1 YEAR	(44			BIRTNPLACE (State or Foreign Country)		
æ	90. FACILITY NAME (If not institution, give stre Sinai Hospit		9		R LOCATION OF DE	ATN	9c. COUNTY			
5	RESIDENCE OF DECEDENT						1 11/			
DIRECTOR	MD • 10b. COUNTY NA			timor				10d. INSIDE CITY LIMITS? 1ALYES 2 NO		
FUNERAL	10e. STREET AND NUMBER 2434 W. Belvedere Ave.			101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?		
NE.		ere Ave. 12. WAS DECEDENT EYER IN U.S	LABMED	13. WAS DEC	212		US.	RACE - American Indian.		
B≺	1 X Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2 IF YES, GIYE WAR OR DATES	X Xo	D 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea if yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 ☐ YES 2X MO Specify:				Specify: Black Specify: Black		
	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION 16e	(Give kind of wor	CEDENT'S USUAL OCCUPATION ve kind of work done during most of working				TRY		
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5 +)			Aborer Con			nstruc	tion		
BE CON	17. FATHER'S NAME (First, Middle, Last) UNK •				18. MOTNER'S NAI	ME (First, Middle, Maid	en Surname)			
TO B	190. INFORMANT'S NAME (Type/Print) Ruth Monroe		19b. MAILING A 861 P	ark A	ond Number or Rural F Ve Balt	imore, MI	own, Stete, Zip Co	0 1		
	20b. METNOD OF DISPOSITION 1 X Mariel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cremetory or other place) Mt. Zion Cem. 11-15-95 Lansdowne, MD.									
	21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAME A	ND ADDRESS OF FA	CILITY				
		1000				Wylie I				
	IMMEDIATE CAUSE (Finel disease or condition	st only one ceuse on each	line.			h aa cardiac or re	apiratory arrea	Approximate Interval Between Onset and Daeth		
	DUE TO (OR AS A CONSEQUENCE OF):									
Z	Sequentially list conditions, CEREBROASCUAR ACCIDENT									
ATIO	Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate cause. Enter UNDERLYING									
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):							
EH	d destription									
AL	MALNUTRITION ANEMIA PERFORMED? AMAI							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?		
PHYSICIAN: MEDIC								1 TES 2 NO		
AN	DID TOBACCO USE CONTR		PLACE OF DEATH			1 🗷				
SICI	EXAMINER?	HOSPITAL:		OTHER:	ne 5 🗆 Residence	6 Other (Specify)				
H	27. MANNER OF DEATN	26e. DATE OF INJURY (Month, Day, Yeer)	26b, TIME	OF 28c. IN	JURY AT	26d. OESCRIBE NO	W INJURY OCCUI	RED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(1131.11, 22), 134)			YES 2 NO					
	3 Sulcide 6 Could not be determined 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 26f. LOCATION (Street end Number or Rural Route Number, City or Town, State)							Rural Route Number,		
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.									
							BIGNED (Month, Day, Year)			
O BE		segal, DO			A524023	21 PS 9945	> 11	-13-95		
5	PAVL SEGAL,	NALS OID CO	920H H		BELVEDER	E AVE	BALTIMO	RE, MD		
	NOV1 6 1995 Jale	32 REGISTRAR'S SIGNATU	IRE							

AN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	tificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	n, or removal.	e medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execu	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE OF MARYLANI 1 - REGISTRAR	D / DEPARTM CERTIFICA			MENTAL HYGIEN					
- 8	1. DECEDENT'S NAME (First, Middle, Last)	02.11111107	112 01 1	JEAIN	2. DATE OF DEATH			TIME OF DEATH		
- 0	Mary Margaret Cushing					4 19	95	8:20 pm		
		MON					B. BIRTHPL.	ACE (State or Foreign		
i i	219-26-4103 1 M 2 X F 5	19-26-4103 1 M 2 X F 58 YRS. August 1, 19								
DIRECTOR	The Good Samaritan Hospital	Balt	imore		N	/A				
E I	10e. STATE 10b. COUNTY	10c. CITY, TO	WN OR LOCATIO	ON			10	INSIDE CITY		
	Maryland N/A		Balti 101. 2	more		1 YES 2 □ NO 10g. CITIZEN OF WHAT COUNTRY?				
E3	4204 Woodlea Avenue			21206				States		
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced 12. WAS OCCEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	X NO	If yes, spec	NDENT OF HISPAN	IC ORIGIN? (Specify Yon, Puerto Ricen, etc.)		4. RACE -	American Indian, White, etc.		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e	DECEDENT'S USU (Give kind of work	AL OCCUPATION	of working	16b. KIND OF BU	JSINESS/INDU	STRY	MITTE		
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5 +)	life. Do NOT use reti	etired.)			n Home				
Š	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAI	ME (First, Middle, Meide						
BE (Theodore Letke	,	Mary	Friel						
2	19e. INFORMANT'S NAME (Type/Print)				Route Number, City or To					
	Mr. Richard T. Cushing			a Avenu		imore,		21206		
	20e. METHOD OF DISPOSITION 1 Dariel 2 Si Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of centerly, crematory or other place) Hillton Service (Corporation 11/16/95 Towson Maryland									
10	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T 7240472 22. NAME AND ADDRESS OF FACILITY									
113	Mark T. Zam	voyna	Leona	rd J. R	uck, Inc.	1+1-0		44 21214		
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, ehock, or heart fellure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel Approximate intervel Between Onset and Death									
	disease or condition resulting in death)	iAL AM	AL TAMPONADE SEQUENCE OF:					ONE DAY		
	TUMOR INVADING LUNG & PERICARDIUM									
S O	Sequentially flat conditions, DIF TO (OR AS A COMSEQUENCE OF).									
ξ	cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	resulting in death) LAST									
	PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceues given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
CAL	PANALARY FARRISM DEED VEIN Theomores							MALABLE PRIOR TO OMPLETION OF CAUSE		
PHYSICIAN: MEDIC								F DEATH?		
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
IAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
Sic	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inputent 2 ER/Outpatien		HER: Nursing Home	5 Residence	8 Other (Specify)					
E	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJUI		28d. DESCRIBE HOW	INJURY OCCU	JRED			
BY	1 Netural 5 Pending 2 Accident Investigation		M 1 YE							
a	3 Suicide 8 Could not be determined 289. PLACE OF INJURY — A building, etc. (Specify)	At home, ferm, stree	t, tectory, office		28t. LOCATION (Street City or Town, State		or Rural Rou	te Number,		
COMPLET	29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge	a death assumed as	Ab a Alman I data a	-4 -14 4	4-44					
M	(Check only one) 2 MEDICAL EXAMINER: On the basis of exemination and							nd manner ee stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER	(-11-11-11-11-11-11-11-11-11-11-11-11-11		29c. LICENSE NUN						
TO BE	Mohim MD			D 476	89	► Nou	iember	e 14, 1995		
-	JAMES APPIAH - PippiM	(ITEM 27) (Type, Prin	()	to the	spital	5601 L	ochR	AVEN BHD.		
	31. THE (Manth Con Year) 2. REGISTRAR'S SIGNATUR	NE OOOD	JAMAR	CILWN LIC	opilar	Baltin	TORR,	~10.		
- 1	NIIV 1 @ 700E / / I - I									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

It	em19b 11-16-95 File 1 - STATE 1 - STATE	mG729 W H PAN STATE OF MARYLANI	F/H D' DEPAI	RTMENT O	F HEALTH AN	ID MEN	NTAL HYGIENI		3	4602
	REGISTRAN		CERTIF	ICATE C	F DEATH		REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)						DATE OF DEATH	٧ ١	/EAD	TIME OF DEATH
	Marcellus	Carrin	igton			No	ovember]		95	8:40 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs.		IF UNDER 1 YE		RS. 7. C	Month Day Year	8	. BIRTHPLA Country)	CE (State or Foreign
	220-14-5643	1 M 2 D F	59 YRS.	MONTHS	/S HOURS MI	" J	an.6, 19	26	Virgi	inia
	9e. FACILITY NAME (If not institution, give str			96. CITY, TOY	MN OR LOCATION O	OF DEATH		9c. COUNT	Y OF DEATH	
O B	6214 Fortview Way	r		Balt	imore			N/A	1	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		1 10 - 017	TY, TOWN OR LO						
E		I/A		Baltimo						1. INSIDE CITY LIMITS?
	Maryland N	1/A		Dallin						YES 2 NO
RA		_			10f. ZIP CODE 21224			112		COUNTRY?
FUNERAL	6214 Fortview Way								.A.	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO NO	If yes	s, specify Cuben, Me	exican, Pu	RIGIN? (Specify Yea lerto Rican, atc.)	or No- 1	Black, WI	American Indian, hite, atc.
84	3 ☐ Widowed 4 ☑ Divorced	IF YES, GIVE WART OR DATES		1 🗆	YES 2X NO S	Specify:			Specify:	Black
	15. DECEDENT'S EDUC	ATION 18a	. DECEDENT'S	S USUAL OCCUP	PATION		16b. KIND OF BUS	INESS/INDUS		DIGCK
ETE	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4 or 5 +)	(Give kind of life. Do NOT u	work done during use retired.)	g most of working		1000 1000			
4	9th — La			rer	rer Furni			ure Co	mpany	У
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)									
	David Carrington Grace Brown									
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (St	reet and Number or R	Rural Route	Number, City or Town	n. State, Zip C	ode)	
일	Lucy Pryor		2101	E. Mad	ison Str	ect/	Baltimor	e, MD	2120	5
	20e. METHOD OF DISPOSITION	20b. PLA	CEANDOATE	OF DISPOSITIO	N/Name of		DATE 20c LO	CATION — CH	by or Town	State
	1 X Burial 2 Cremetion 3 Remo	val from State cemetery.	crematory or (Porest	VA Cemet	terv	11-16 0	wings	Mill	s, MD
	21. SIGNATURE OF FUNERAL SERVICE LICE	BARE V		22. NAM	E AND ADDRESS O	DE FACILIT	Υ	*****	****	57.12
	* Walnu	too!		Marc	ch Funera	al H	ome Last venue/Ba	ltimor	e. Mi	0 21202
\vdash	23. PART I. Enter the diseases, or co	omplications that gauged the	death De							
	ahpck, pr haart fallura. L	Ist only one cause on each	lina.	not enter tha	moda or dying,	auch aa	cardiac or respi	ratory arres	pt,	Approximate Interval Batween
	iMMEDIATE CAUSE (Final disease or condition									Onset and Death
	resulting in death)	DUE TO (OR AS A CON	ARDIA	HC AAI	aest					-
1_1		COROWARY	Secuence C	(e):	nisem	52				
IFICATION		DUE TO (OR AS A CON	NSEQUENCE C	DE:	0.00,10	-				
I E	if any, leading to immediate cause. Enter UNDERLYING	BI BLEC		n.*						ĺ
[윤]	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A COM		OF):						
1 등 1	resulting in death) LAST									
핑										
	PART II. Other significant conditions	contributing to death but n	ot rasuiting	in the under	lying cause giva	n in Parl	1 i. 24a. WAS AN PERFOR			RE AUTOPSY FINDINGS
MEDICAL							1 YES 2			MPLETION OF CAUSE DEATH?
핗		0.000				YES 2 NO				
ä	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF D	EATH Y	ES NC	UNCER"	TAIN	X			
N N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEA	ATH (Check only	one)					
Sic	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatien	n 3 🗆 DOA	OTHER:	Home 5 Reside	ence 8 🗍	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TII	ME OF 280	:. INJURY AT WORK?	280	d. DESCRIBE HOW I	NJURY OCCU	IRED	
BY F	1 Natural 5 Pending Investigation	(YES 2 NO	0				
9	3 Sulcide 8 Could not be	28a. PLACE OF INJURY — A building, etc. (Specify)	it home, ferm,	atreet, factory,	office	281	LOCATION (Street a City or Town, State)	and Number of	r Rurai Route	Number,

1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the beels at exemination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.

36 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

DARRYC A H (C Z 8

31. DATE FILED (Month, Day, Year)

NOV 1 6 1005 January Manualian Royal HICC 78 S.

29c. LICENSE NUMBER

BE COMPLETED

2

4 Homicide

29e. CERTIFIER (Check only one)

29d. DATE SIGNED (Mpnth, Day, Year)

HE

REG. NO.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

FOR STATE REGISTRAR

	ļ	1. DECEDENT'S NAME (First	, Middle, Last)	Laurett	a Cla	a Con	еу			2. ONTE OF I	DEATH DAY
		4. SOCIAL SECURITY NUMBER	a -	SEX	8. AGE (In yrs		IF UNDER 1 YE	40 25 100	CD 24 400	Varen os	n Dal
		215-09-4246		□ M 2 🔏 F	85	YRS.	MONTHS DA			(Month, Da	y, Year)
3 should		9a. FACILITY NAME (If not in							ER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) April 23,1 THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF DEATH THON OF BUSH State of THER'S NAME (First, Middle, Melden Size of Chmielewsking) There's Name (First, Middle, Melden Size of Chmielewsking) T		
2, 3 s	0R	54 Acorn Cir		Apt.203	3		10	owson			
les 1,	DIRECTOR	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN OR L				
if. Pag		Maryland	Bal	timore	Co.		To	noswo			
n. ansit perm	FUNERAL	54 Acorn Cit		Apt.203	3			101. ZIP CC	21204		
by the hospital or attending physician. be detached for use as the burial-transit permit. Pages 1, 2, at once.	B	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 K Divo	Merried	FORCES? 1 IF YES, GIVE W	YES 2	ARMED	If ye		ban, Mexica	in, Puerto Ricar	
attending use as the	밀		EDENT'S EDUCAT		18e	(Give kind of	Work done durin	PATION g most of wor	rking	18b. KIN	O OF BUSI
the hospital or detached for u	COMPLET	Elamentary/Secondary (I		college (1-4 or S	•)	Sec	retary				
	BE CO	17. FATHER'S NAME (Flist, M Kazimierz L	ewandows	ki							
y be retained to	5	Mrs. Pamela	Thomas-						Mil	lersvi	lle,
e 6 ma ector, g		20a METHOO OF DISPOSIT 1 ABurial 2 Crematic 4 Donation 5 Other	r (Specify)		Stery	Stani	of dispositions	Cem.			Dunc
		21. SIGNATURE OF FUNERA	y J	Jan_	frey L	. Gair	Leo	nard	J. Ru	ck, In	
ns af		23. PART Enter the d	iseasea, or can leart feilure. Lis	plications the	1 caused the	death. Do					
within 24 pletely fill cremation.		iMMEDIATE CAUSE (Fit disesse or condition resulting in death)		Arte	7705 (OR AS A COI	Jano	olie (g drdi	10Re	ens/	1/250
beath certificate be executed attending physician and comma Hygiene prior to burial, y, or other traumatic ev.	RTIFICATION	Sequentially list condit if any, leeding to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initieted events	diete		(OR AS A COI						
te death certi the attending Mental Hygie Jury, or ott	CERTI	resulting in deeth) LAS	d								
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he law requires been a Dept. of h	∑ Z	DID TOBACCO U	JSE CONTRIE	SUTE TO CA	USE OF D	EATH Y	ES NO	UN 🔲 C	ICERTAI	NE	
N: The la ficate has State De item 2	PHYSICIAN:	25. WAS CASE REFERRED T	H	OSPITAL:			OTHER:		/		
SICIAN certific the S	HYS	1 Nes 2 No	1	28e. DATE OF	INJURY	28b. TII	ME OF 280	c. INJURY AT	Residence		
DING PHYSICIAN: The After this certificate death with the State smarked, or item	ВУ Р	t Natural 5 🗌	Pending investigation	(Month, E	lay, Yeer)	IN	M 1	WORK?	NO		
TOR: after 28 i	B	2 Devlotes	Could not be determined	28a. PLACE C building,	etc. (Specify)	t home, larm,	atreet, lactory,	offica			
TAL OR TAL DIRI 72 hour	COMPLET	2000									
TO THE HOSPITAL TO THE FUNERAL De filed within 72		295. SIGNAPORE AND TITLE			7			-			
TO THE De filed IMPOR	BE	John	elen	102	lon	00 0	MIL	200	-09	383	
	2	30. NAME AND ADDRESS O	F PERSON WHO	OMPLETED CAU	SE OF DEATH	(ITEM 27) (Typ	e, Print)			101	
20		31. DATE FILED (Month, Day	HO (E	32. REGISTER	AR'S SIGNATUI	-///	Xlim	14/9	41/	15d-1	B2/
8		12114	1000		velen-R						
		NUV 1 6	1	Jan Wall	year FU	- Usery					

6. BIRTHPLACE (State or Foreign 23,1910 Maryland 9c. COUNTY OF DEATH
Baltimore Co. 10d. INSIDE CITY LIMITS? 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? 14. RACE — American Indian, Black, White, atc. Specify: White etc.) OF BUSINESS/INDUSTRY e of Maryland Melden Surname) **ewski** Te, Mary land 21108 20c. LOCATION - City or Town, State Dundalk, Mary land 1timore, Maryland 21214 Approximate Intervsi Between Onset and Death WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 AM OF DEATH? 1 YES 2 NO E HOW INJURY OCCURED (Street and Number or Rural Route Number, n, State) lace, and due to the cause(s) and menner as stated. 29d. DATE SIGNED (Month, Day, Year)

DHMH-16 Rev 1/89

Pages 1, 2, 3 should

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DIRECTOR:

31. DATE FILED (Month, Day, Year)

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32. REGISTRAR'S SIGNATURE

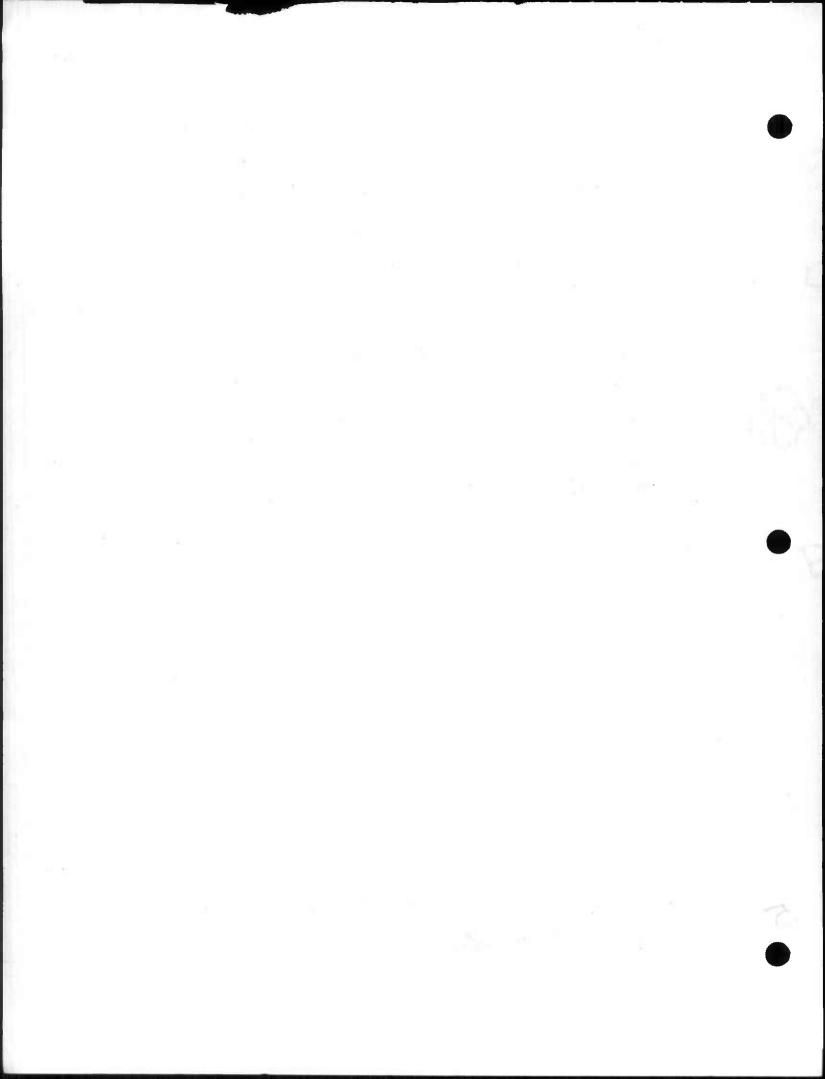
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DIVISION OF VITAL RECORDS, F.O. BOX 88780	6
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** BEG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 1995 NOV. BESSIE CHAMBERS 1455 Рм 6, 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) March 17 5 SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR DAYS HOURS 1 M 2 F 47 1948 214-58-5173 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1401 NORTH LAKEWOOD AVENUE428 DIRECTOR BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland n/a Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? Apt. 428 1401 North Lakewood Avenue 21213 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. II yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Married BY Specify: 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Technician Western Electric 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Maiden Surname) 7 Samuel Taylor Bessie Clark 8 notified a 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Lewis Taylor 3712 Cedar Drive Baltimore, Maryland 21207 pe 20. METHOD OF DISPOSITION
113 Buriel 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND OATE OF DISPOSITION (Name of NONTE must King Memorial Park 4 Donation 5 Other (Specify) 13 Baltimore County, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Dary Collen α . Baltimore, Maryland 21216 medicai 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock or heart failure. List only one ceuse on each line. Approximate intervel Between **Onset and Death** IMMEDIATE CAUSE (Fine) the diseese or condition ATHEROSCIE DOTIC CAMINING MUNIC DISADSE reculting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in deeth) LAST 5 Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL any MELLITUS COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? Shows 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item OTHER:
4 □ Nursing Home 5X Mealdence 6 □ Other (Specify) HOSPITAL: 1XXES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ŏ 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY --- At home, farm, atreet, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be datarmined 69 COMPLETED 200 tem 29a. CERTIFIER
(Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. FUNERAL (within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. SHONATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 띪 ▶ NOV. 07, 1995 O.C.M.E Nete 9 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. KOREW Un111 Penn Street, Baltimore, Maryland 21201 RYPOLITA



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the busident physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTABLY: If them 28 is marked, on item 23 shows any Inlury, or other traumatte event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	STATE OF MARY			F HEALTH AND I	MENTAL HYGIEN	_		
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	N AEY	3. TIME OF DEATH	
1 1	JEANN	CA	LVIN		NOVEMBER D	12,1995	1:40pm w		
	4. SOCIAL SECURITY NUMBER 214–40–4835		E (In yrs. lest birthday)	MONTHS DA		7. DATE OF BIRTN (Month, Day, Year)	8. B	INTHPLACE (State or Foreign ountry) IARYLAND	
OR	9a, FACILITY NAME (If not institution, give Longe 74 MERIDIAN LONG 74		OME		VN OR LOCATION OF DE JTIMORE	ATH	9c. COUNTY O		
[[[RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ	10c. CF	TY, TOWN OR LO	CATION			tod. INSIDE CITY	
L DIRECTOR	MARYLAND CARR		ELDE	RSBURG 101, ZIP CODE		10a CITIZEN	t X YES 2 NO		
RA		WANT DE UD				0.4	log. Officer	USA	
BY FUNERAL	6313 G. GEORGETOWN BLVD. 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Wolvorced 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2, IF YES, GIVE WAR OR DATES			NO If yes, specify Cuban, Mexican, Puarto Rican, etc.)			1	RACE — American Indian, Black, White, atc. Specify: WHITE	
8	15. DECEDENT'S EDU		16a. DECEDENT'S	S USUAL OCCU	PATION	16b. KIND OF BUS	SINESS/INDUST	RY	
COMPLET	(Specify only highest grad	College (1-4 or 5+)	life. Do NOT u	use retired.)	TEACHER		EDUCAT	TION	
Š	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	1	
ш	JACOB	H	ETTLEMAN		LENA		В	ERMAN	
TO B	198. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stelle, Zip Code) MRS. MARCY MARSH 4231 18th ST. SAN FRANCISCO, CA 94114								
	20g. METHOD OF DISPOSITION 1 Burlei 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACEAND DATE Of DISPOSITION (Name of Cartino City) or Town Cartino Company (Name of Cartino City) or Town Cartino Company (Name of Cartino City) or Town Cartino Company (Name of Cartino City) or Town Cartino City or Town City or Town City or Town City or Town								
	21. SIGNATURE OF FUNERAL SERVICE L		101 05	SOI	E AND ADDRESS OF FA	& BROS.,	INC.	MORE, MD 21215	
ERTIFICATION	shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury. Due to (or as a consequence of): Due to (or as a consequence of):								
CERTII	that initieted events resulting In death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.								
MEDICAL	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DE	-	one)	1			
SIC	1 YES & NO	1 Inpatient 2 ER/O	Outpatient 3 DOA	OTHER:	Home 5 - Residence	6 Other (Specify)			
ВУ РН	27. MANNEY OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJU! (Month, Day, Yes		JURY	WORK?	28d. OEŞCRIBE HOW	INJURY OCCURE	ED .	
<u>a</u>	2 Accident Investigation 3 Suicide 6 Could not be determined 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								
COMPLET	29e. CERTIFIER (Check only	SICIAN: To the best of the ki	1					susse(s) and manner as stated	
TO BE CO	296. LICENSE NUMBER 296. LICENSE NUMBER 296. OATE SIGNED WARDING AND TRAIN 296. OATE SIGNED WARDING								
	AND ADDRESS OF DERSONS	CENTRE CAUSE OF	DEATH (ITEM 27) (Typ	oa, Print) THOLP	tries an	EI BALTO	. M. J.	21222	
	31. OATE FILEO (Month, Day, Year)	32. REGISTRAR'S S	GALL						

BALTIMORE, MARYLAND 21215-0020

BOX 6876 P.0. DIVISION OF VITAL RECORDS.

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Pages 1, 2, 3 should permit. use as the burial-transit Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for Once. ¥ notified be must examiner hours after death. and completely filled in by the bunal, cremation, or removal. medical the event, executed traumatic 9 signed by the attending physician and Health and Mental Hygiene prior to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be other 10 any shows ? JCIAN: The discrete has been the State Dept. of Hr and 23 sh with b marked, DIRECTOR: After the hours after death vitem 28 is mark TO THE HOSPITAL OF THE FUNERAL DE BE fied within 72 ho

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR SYLVAN м CHERNEY NOV.11, 1995 9:30 A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign DAYS HOURS 81 1 X M 2 - F 215-01-8945 YRS. MAR.14 MD 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SUBURBAN HOSPITA; Hospital BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD MONTGOMERY BETHESDA 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5225 POOKS HILL ROAD APT. 9045 20814 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ▼ YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried if yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 TES 2 XNO Specify Specify BY 3 Wildowed 4 Divorced WWII WHITE ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) WHOLESALAER Wholesaler CANDY AND TOBACCO COMPL 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) CHERNEY **ABRAHAM** MARY **JACOBS** BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 5225 POOKS HILL RD, APT.9045; BETHESDA, MD 20814 MRS. ERMINE CHERNEY 20e, METHOD OF OISPOSITION
1 M Burlel 2 □ Cremetion 20b. PLACE AND DATE OF DISPOSITION (Name of 20c, LOCATION - City or Town, State DATE 1 Buriel 2 Cremetion 4 Donetion 5 Other CHIZUK AMUNO(ARLINGTON) 11+13-95 BALTIMORE, MD 21. SIGNATURE OF FUNESIAL SERVICE LIGH 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 applications that coused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, **Approximate** shock, or heart fatture. List only one cause on each line Interval Between Onset and Death IMMEDIATE CAUSE (Fine) radue Cancr 3420 diseese or condition resulting in death) CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evente resulting in death) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one **EXAMINER?** HOSPITAL:
1 postient 2 ER/Outpatient 3 DOA 1 YES 2 NO OTHER: 4 - Nursing Home 5 - Reeldence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE DF INJURY (Month, Day, Year) 26c, INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide

29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. (Check only one) 2 MEDICAL EXAMINER on the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated.

29b. SIGNATURE AND TITLE O 29c. LICENSE NUMBER 332

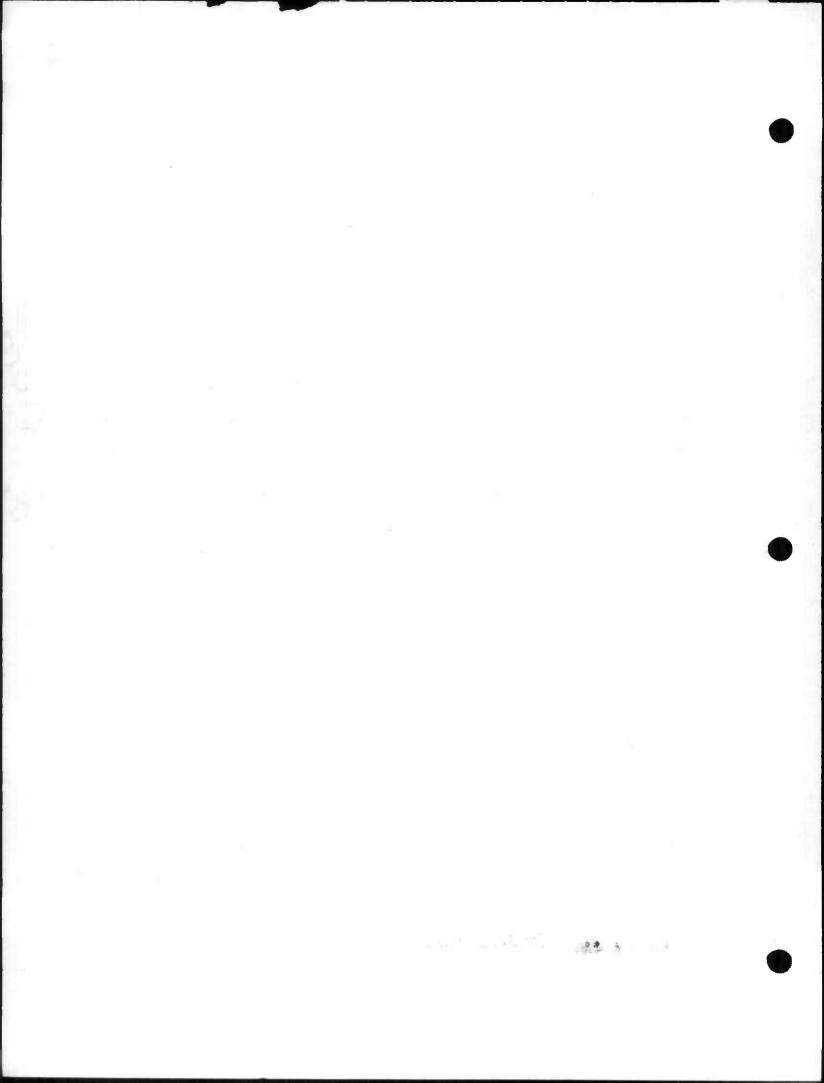
30. NAME AND ADDRESS OF PLETED AUSE OF DEATH (ITEM 27) (Type, Print) 5401 WESTERN AVE. DR. FRED SMITH

WASHINGTON, DC 20015

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Divideor Randall

DHMH-18 Rev 1/89

29d. DATE SIGNED (Month, Day, Year) 9



3. TIME OF DEATH

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Approximate Intervel Between Onset and Death SHAR.

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 | YES 2 | NO

BIRTHPLACE (State or Foreign Country)

MARYLAND

PM

REG. NO.

10

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year)

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NOV

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DONALD

4. SOCIAL SECURITY NUMBER

213-28-7877

CONWAY

1 2 M 2 F

6. AGE (in yrs. last birthday)

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. OR	DIRE	hours
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral din	vithin 72

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-		9e. FACILITY NAME (If not institution, give street and number)				19	9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH		
(СТОВ	ST. AGNES HOSPITAL					BALTIMORE CITY				N/A		
٠,	[[[RESIDENCE OF DE	10b. COUNTY	,		10c CITY	TOWN OR LO	ATION				T 104	I. INSIDE CITY
- P	DIRE	MARYLAND		ALTIMORE	1								LIMITS?
sit permit.		10e. STREET AND NUMBER		ALTIMORE			CATONS	V LLLC 10f. ZIP CODE			1 YES 2 NO		
	ERAL	303 MAIDEN CHOICE LANE, APT. 314											
cian. I-tran	FUNE	11. MARITAL STATUS	OHOLO	12. WAS DECEDENT EVE		ED	13. WAS D	21228 ECENDENT OF HISPA		pecify Yes		S.A.	American Indian,
physician. burial-transit		1 Never Merried 2 🗵	Merried	FORCES? 1 X YI			If yes,	specify Cuben, Mexic ES 2 X NO Speci	an, Puerto Rica			Black, Wh Specify:	ilte, etc.
	BY	3 Widowed 4 Div	orced	1-12-51	1-20-	-54	'''	LO ZĄŁ NO OPOCI	·y.			Specify.	WHITE
r attend	윤					S USUAL OCCUPATION work done during most of working 16b. KIND OF BUSINESS/INDUSTRY							
for u	LET	Elementery/Secondary	(0-12)	College (1-4 or 5+)	life. D	NOT use	retired.)						
24 hours after death. Page 6 may be retained by the hospital or attending filled in by the funeral director, page 5 should be detached for use as the tion, or removal. The medical examiner must be notified at once.	COMPL	6				ROOF	ER				ONSTRU	CTIO	N
	8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surneme)							
	1 141 1	JAMES H. CONWAY 190. INFORMANT'S NAME (Type/Print) 190. MAILII					MARY HELEN HARE LING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	임	Company of the second	***										
ay be		SHIRLEY L.			20b. PLACE AN			HOICE LN.	APT.		BALT.		
ector, pector, p		t ☐ Burlel 2X Cremeti	lon 3 🗆 Rem		CHESAP								MARYLAND
Page I dire		21. SIGNATURE OF FUNER			OHLDM	LAKE		AND ADDRESS OF FA		I DE	PISATE	ا وعاماً	MAKILAND
ter death. Page 6 m the funeral director, wal.		Klink	10 -	Alast	_		STER	LING ASHI	ON FUN	ERAL	HOME,	INC	
24 hours after de filled in by the f on, or removal.		1 444	ugo	Vuito				EDMONDSON					
		shock, or	haart fallure.	complications that cau List only ona cause or	sed the gee n aach lina.	th. Do no	t enter the i	node of dying, su	ch as cardled	or respli	ratory erresi		Approximate Intervel Betwe
	- 1	IMMEDIATE CAUSE (Final disease or condition										Onset and Da	
		resulting in death)	\rightarrow	a. MASSI	VE A	MACA	MEDIAL	INFAR	CTON				SHAL-
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and and bur	RTIFICATION	Sequentially list condi	tions,	DUE TO (OR A	S A CONSECU	JENCE OF):	Croy	PI-LOV-E					
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g phy iene (E	that initiated events DUE TO (OR AS A CONSEQUENCE				JENCE OF):	:						
eath certil attending ntal Hygien	F	resulting in deeth) LA	ST	c. HE	ART	FAIL	URE						WOCK
the atte Mental	CE	PART II. Other signific	ent condition	ns contributing to deet	h but not re	sulting in	the underly	ing ceuse given in	Part I 24	a. WAS AN	AUTOPSY	24h WE	RE AUTOPSY FINDIN
and in	EDICAL			VASCULA				mg over given i		PERFOR	MED?	AVA	ILABLE PRIOR TO MPLETION OF CAUSE
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v requirements of P	Σ	DID TORACCO I	ISE CONT	RIBUTE TO CAUSE	OF DEAT	H YES	I NO	□ IINCEPTA	N D			1 1	YES 2 NO
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certificate the State	SIC	EXAMINER?		HOSPITAL:	Outpatient 3		OTHER:	ome 5 🗆 Reeldence	e Other (C				
SICIA certif	· >	27. MANNER OF DEATH		28e. DATE OF INJUI	RY	28b. TIME	DF 28c.	INJURY AT	*		JURY OCCUP	RED	
Wer this ce	7		Pending Investigation	(Month, Day, Yea	nr)	INJU		WORK?					
After deat	D BY	2 Accident 3 Suicide	Could not be	28e. PLACE OF INJI	URY — At hom	e, term, str	street, factory, office 28f. LOCATION (Street			and Number or Rural Route Number,			
CTOR affer		4 Homicide determined building, atc. (Specify)											
L OR ATTENDING P DIRECTOR: After the hours after death vitem 28 Is mark	2	29e. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner se stated.											
HOSPITAL FUNERAL within 72 I		cont diny		R: On the basis of exemin								/	d manner es atated
FUN With	ŭ	296. SIGNATURE AND TITE	E OF CERTIFIE	R				29c. LICENSE NU	IMBER				onth, Day, Year)
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate bas been signed by the attending physician be finded within 72 hours after death with the State bept. of Health and Mental Hygiene prior in MEDIETANT: It item 28 is marked or item 23 shows any Inlury, or other trau) BE	Malone	MEDIC	AL RESIDE	ENT			0/8	9				,1995
		Contract of the last of the la										/	

30. N ME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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900 CATON AVE.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS.

DHMH-16 Rev 1/89

Pages 1, 2, 3

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed HOSPITAL TO THE HOSPITA
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De filed within 7.

95 34608 ITEMS: 12.17.19b, 20b, PER F.H. FILM G-729 11/16/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH William E. Dix 13 1995 8:54 PM Nov 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 6-4-1930 216-24-9585 65 DAYS HOURS 1 X M 2 T F 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH St Joseph Hospital Towson Balto DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b, COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? N/A Baltimore 1 YES 2 NO Md FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3103 Milford Avenue USA 21207 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 X XYES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married 1 TYES 2 X NO Specify: Specify: **Black** BY 3 Widowed 4 Divorced NO DISCHARGE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade N/A Bethlehem Steel Laborer once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Dix to Charles Cix DIX notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 1415 Vida Drive Baltm BALTO. Md 21207 Barbara Murray pe 20a. METHOD OF DISPOSITION
1 Suriet 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Park 11/17/95111797 Randallstown, Md King Memorial medical examiner 22. NAME AND ADDRESS OF FACILITY
March F/H West 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wabash Avenue Balto, Md 21215 all. 4300 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate Interval Between ahock, or heert feliure. List only one cause on each line. Onset and Death IMMEDIATE CAUSE (Finel the diseese or condition resulting in death) Massive pulmonary embolus (saddle embolus) Immediate event. DUE TO (OR AS A CONSEQUENCE OF): Status post below knee amputation of left leg traumatic Days CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING c. Atherosclerotic peripheral vascular disease
DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Injury Years or other that initiated events resulting in death) LAST Diabetes mellitus, hypertension injury. PART II. Other eignificent conditione contributing to death but not reculting in the underlying ceuee given in Pert I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL any 1 X YES 2 NO e has been signer e Dept. of Health m 23 shows a OF DEATH? 1 X YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA **EXAMINER?** OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) e the 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural М 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 69 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be DIRECTOR: / hours after of item 28 is COMPLETED 4 Homicide 29a. CERTIFIER

(Chark only I CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and menner as stated. = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CORDIFIER BE Pa flutogent teven

ST JOSEPH MED, CIR,

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

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O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be estained by the hospital or attending physician. OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for the purple of the page 2, 3 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

95 34609 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 207 Ernestine xon 11 3 Am 4. SOCIAL SECURITY NUMBER 7. OATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State Country) 5. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. or Foreign 215-56-400 MONTHS DAYS HOURS MIN 1 M 2 DE mar 5 130 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH osl Nursins BAltimore CITY Ua emden DIRECTOR N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? marylari Himore 1 TES 2 NO N/A CITY 100. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? USA rette rac 21223 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 TO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cutsin, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Neger Merried 2 Merried IF YES, GIVE WAR OR OATES BY 3 Widowed 4 Divorced ETED 16s. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL NONE NONE 8TH N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Ni Percy Annie cholson BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SANDRA JACKSON 1318 N. BOND STREET BALTO, MD. 21213 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Mt. ZiON Nov. 18 1995 MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 2121 23. PART I. Enter the diseases, or complicatione the ceased the death. Do not enier the mode of dying, such as cerdiec or respiratory street, Approximats shock, or heert failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Squamons Cell carcinomes (Dbs tructure DUE TO (OR AS A CONSEQUE) CE OF CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL the Reymostly soil icm PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF OEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN 28. PLACE OF OEATH (Check only o 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 Nursing Home 5 Reeldence 8 Other (Specify) 1 TES 2 NO 27. MANNED OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending ВУ 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide determened

1 ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end piece, end due to the ceuse(e) end menner ee stated.

PLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

eman 32. REGISTRAR'S SIGNATURE

2 MEDICAL EXAMINER: On the beste of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated, 29d. DATE SIGNED (Month, Day, Year)

OHMH-18 Ray 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pe	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bun'al, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notifiled at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

	FOR STATE REGISTRAR	STATE OF M					EALTH AND	MENTAL HYGIEN	_	70	04010
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH
	MICHAEL	HENF	V		Г	ONN	ELLY	MOVEMBER	AY 1	YEAR	12:30 PM
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. la:	st birthday)	IF UNDER		IF UNDER 24 HRS.	7 OATE OF BIRTH			LACE (State or Foreign
	212-58-7099	1 📝 M 2 🗆 F	43	YRS.	MONTHS	DAYS	HOURS MIN.	Oct 15,	1052	Country)	vland
	9a. FACILITY NAME (If not institution, give st	41	45	_	9b. CITY, TOWN OR LOCATION OF DEATH					NTY OF DE	
OR	12 WYEGATE COUP						MILLS	zain		LTIM	
[[RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,		I soc CIT	Y, TOWN O	R I OCAT	ION			1	IOd. INSIDE CITY
DIRECTOR		imore			altir						LIMITS?
FUNERAL	10a. STREET AND NUMBER					101	ZIP CODE		10g. CIT	IZEN OF WI	AT COUNTRY?
띮	5901 Edmonson Ave	nue					21228		Uni	ted S	tates
5	11. MARITAL STATUS	12. WAS DECEDENT						NIC ORIGIN? (Specify Ye	a or No-	14. RACE	- American Indian,
	1 Never Married 2 Married	IF YES, GIVE W	YES 2X	NO			2 X NO Specif	in, Puarlo Rican, atc.)		Specify	White, etc.
BY	3 Widowed 4 Divorced										White
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade	CATION	16a. Di	ECEDENT'S	USUAL OC	CUPATIO	N st of working	16b. KIND OF BU	ISINESS/INI	DUSTRY	
回	Elamentary/Secondary (0-12)	College (1-4 or 5+	life	Do NOT us	se retired.)	iunny mo	st or working				
릴	7		La	abore:	r			Siding	IS & I	Windo	W
Ö	17. FATHER'S NAME (First, Middle, Last)				***		18. MOTHER'S NA	ME (First, Middle, Maide			
	Henry Donnelly						Ruth	J. Harris	3		
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a		Route Number, City or To		n Code)	
5	Penny Clark						Avenue			T	Ω
	20a. METHOD OF DISPOSITION		7							City or Tow	
	1 ☐ Burial 2X Cremation 3 ☐ Ram	oval from State	20b. PLACE cemetery, cr	ematory or o	ther plece)						
	4 Donation 5 Other (Specify)	CALORE .	Balt-	-wash				11-9 La	aurel	, Mar	yLand
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home, Inc.										
	> Them a.	Calle	200								City 21043
CERTIFICATION	IMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if erry, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE O	F): F):	ICATI	ON				
_	PART ii. Other significent condition	s contributing to						PERFO	RMED?		WERE AUTOPSY FINDINGS AWALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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AN: MEDI	DID TOBACCO USE CONT	RIBUTE TO CA				NO C	UNCERTAI	N 🗆			
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YSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1XXES 2 NO	HOSPITAL:	28. PLA ER/Outpatient	CE OF DEA	TH (Check OTHER 4 Num	only one) 3: sing Horr	e 5 Residenca	8 Other (Specify)			
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1X X SES 2 □ NO 27. MANNER OF DEATH	HOSPITAL:	28. PLA ER/Outpatient INJURY	CE OF DEA	TH (Check OTHER 4 Num	only one) 3: sing Horr 28c. INJ	e 5 Residenca URY AT	8 Other (Specify) 28d. DE\$CRIBE HOW	INJURY OC	CCURED	
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ВУ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicids 8 X Example in the	HOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, D) UNKNO! 28a. PLACE O	28. PLA ER/Outpatient INJURY ay, Year)	CE OF DEA 3 DOA 26b. TIN	OTHER 4 Num NE OF JURY	28c. INJ WC	e 5 Residence URY AT PRK? YES XX NO	8 Other (Specify) 28d. DESCRIBE HOW UNKNOWN	and Numbe	er or Aural Br	oute Number,
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ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X ES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicida 8 X Cook in not be distarmined	HOSPITAL: 1 Inpatiant 2 28a. DATE OF (Month, D) UNK NO: 28a. PLACE O building,	ER/Outpatient INJURY By, Year) FINJURY — At h stc. (Specify)	DOA 26b. TIN IN. UNKNO ome, farm, ND AT	OTHER 4 Num IE OF JURY WN M strest, fact HOME	28c. INJ WC 1	e 5 Stresidence URY AT URY AT VES XX NO	8 Other (Specify) 28d. DESCRIBE HOW UNKNOWN 281. LOCATION (Stree City or Town, Stat) OWINGS MILL	and Number 12 WY S, MD.	er or Aural Ac EGATE 2111	COURT
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1XXES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicida 8 XX evolution to be determined 29s. CERTIFIER (Check only)	HOSPITAL: 1 Inpatiant 2 28a. DATE OF (Month, D) UNKNO 28a. PLACE O building,	28. PLA ER/Outpatient INJURY ey, //ear) EN FINJURY — At h stc. (Specify) FOU my knowledge, d	DOA 26b. TIN UNK NC ome, farm, ND AT	OTHER 4 Num IE OF JURY WN M street, fact HOME	28c. INJ WC 1 Ory, office	e 5 Transidence URY AT PK? YES XX NO e	8 Other (Specify) 28d. DESCRIBE HOW UNKNOWN 28f. LOCATION (Stree City or Town, Stat) OWINGS MILL to the cause(s) and m	and Number 12 WY	er or Bural Bo EGATE (2111	COURT 7
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COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1XXES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicida 8 XX evolution to be determined 29s. CERTIFIER (Check only)	HOSPITAL: 1 Inpetiant 2 28a. DATE OF (Month, Dr. UNK NO) 28a. PLACE O building, ICIAN: To the best of experience of experien	28. PLA ER/Outpatient INJURY ey, //ear) EN FINJURY — At h stc. (Specify) FOU my knowledge, d	DOA 26b. TIN UNK NC ome, farm, ND AT	OTHER 4 Num IE OF JURY WN M street, fact HOME	28c. INJ WC 1 Ory, office	oe 5 Ct Residence URY AT PK? YES XX NO e and place, and dur eath occured at the	8 Other (Specify) 28d. DESCRIBE HOW UNKNOWN 28f. LOCATION (Stree City or Town, Stat) OWINGS MILL to the cause(s) and m time, data and place, a	and Number 12 WY S, MD.	er or Rural Ro EGATE 2111 2111 sted. the csuse(s)	ond manner as stated. Month, Day, Year)
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1X PES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Acobis not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	HOSPITAL: 1 Inpatiant 2 28a. DATE OF (Month, D) UNK NO: 28a. PLACE O building, To the best of extension o	28. PLA ER/Outpatient INJURY ay, Year) F INJURY — At h stc. (Specify) F OU my knowledge, d termination and/or	ZE OF DEA 3 □ DOA 26b. TIN IN. UNK NO ome, farm, ND AT	TH (Check OTHEF 4 Nun IE OF JURY WN M strest, fact HOME	28c. INJ WC 1 Ory, office	URY AT RESIDENCE XX NO e	8 Other (Specify) 28d. DESCRIBE HOW UNKNOWN 28f. LOCATION (Stree City or Town, Stat) OWINGS MILL to the cause(s) and m time, data and place, a	and Number 12 WY S, MD.	er or Rural Ro EGATE 2111 2111 sted. the csuse(s)	SOURT
COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicida 8 X 2004 ont be datarmined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	HOSPITAL: 1 Inpatiant 2 28a. DATE OF (Month, D) UNK NO: 28a. PLACE O building, To the best of extension o	28. PLA ER/Outpatient INJURY ay, Year) AN FINJURY — At h stc. (Specify) FOU my knowledge, d termination and/or	CE OF DEA 3 □ DOA 26b. TIN IN. UNK NC Ome, farm, ND AT eath occurr Investigation	TH (Check OTHEF 4 Num IE OF JURY WN M strest, fact HOME ed at tha t on, in my o	only one) 3: sing Horr 28c, INJ WC 1 Orr, office orr, office sime, data	LIP TO THE PROPERTY AT SERVICE AND THE PROPERTY AND	8 Other (Specify) 28d. DESCRIBE HOW UNKNOWN 28f. LOCATION (Stree City or Town, Stat) OWINGS MILL to the cause(s) and m time, data and place, a	and Number 12 WY S, MD. anner as ats and dus to the NOV	er or Rural Ro EGATE (2111) 2111) sted. the csuse(s) TESIGNED (snd manner as stated. Month, Day, Year) R 7, 1995

3. TIME OF DEATH 2012

10d. INSIDE CITY

1 YES 2 NO

MD 21401

Approximata Intarval Batween Onsat and Death

8. BIRTHPLACE (State or Foreign

Washington, DC

14. RACE — American Indian, Black, Whita, atc.

Specify: White

Sc. COUNTY OF DEATH Anne Arundel

10g. CITIZEN OF WHAT COUNTRY?

USA

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH NOV. 4, 1995 Dorothy C. Eshleman 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 6. AGE (in vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Apr. 17, 1927 HOURS 1 M 2 F 68 577-38-1418 YRS permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis Anne Arundel Medical Center DIRECTOR RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Shady Side MD Anne Arundel 10e STREET AND NUMBER **FUNERAL** 10f. ZIP CODE 11. MARITAL STATUS

11. MARITAL STATUS

12. WAS DECEDENT EVER IN U.S. ARMED FORCES?

1 \[\text{Never Married} \] 2 \[\text{Merried} \] Merried

17. Never Married 2 \[\text{Merried} \] Merried

18. Section 19 burial-transit 20764 hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Maxican, Puerto Rican, stc.) BALTIMORE, MARYLAND 21215-0020 1 TYES 2 NO Specify: BΥ use as the t 3 Wildowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY (500 page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Own Home Homemaker 12 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname)
Louise Schwarzmann Francis M. B. Clarkson notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4922 Rullman Road, Shady Side, MD 20764 Dale Bateman þe 20a. METHOD OF DISPOSITION
1. Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must Buriel 2 | Cremetion | 4 | Donetion | 5 | Other (Specify) funeral director, maryland Veterans Cemetery 11/8 Cheltenham, MD examiner 21. SIGNATURE OF FUNERAL BERVIOE DICENSES 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, n and completely filled in by the to burial, cremation, or removal. the medical 23. PART I. Entar the dise Enter the diseases, or complications that caused the death. Do not antar the mode of dying, auch as cardiac or respiratory arrest, shock, or heart fellure. List pnly one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) OPD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within traumatic event. DUE TO (OR AS A CONSEQUENCE OF) BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING physician prior CAUSE (Disease or injury d by the attending phys other DUE TO (OR AS A CONSEQUENCE OF) P.0. thet initiated events resulting in death) LAST 10 Injury, DIVISION OF VITAL RECORDS, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL any signed b 1 XES 2 NO Shows ur this certificate has been significant the State Dept. of He sarked, or Item 23 show DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN **PHYSICIAN**: 28. PLACE OF DEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1 | Inpstiem 2 | ER/Outpstiam 3 | DOA OTHER:
4 Nursing Home 5 Realdenca 6 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X X Natural Pendine 1 YES 2 NO DIRECTOR; After the hours after death vitem 28 is mark BY 2 Accident 26a. PLACE OF INJURY — At home, farm, streat, fectory, office building, etc. (Specify) 3 Suicide Could not be COMPLETED 4 Homicide 29a. CERTIFIES

(Check on one)

(Certifying Physician: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and menner as stated.

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A REGISTEAR'S EIGNAT THE SALL

Fuller,

TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 ho

BE

Steven

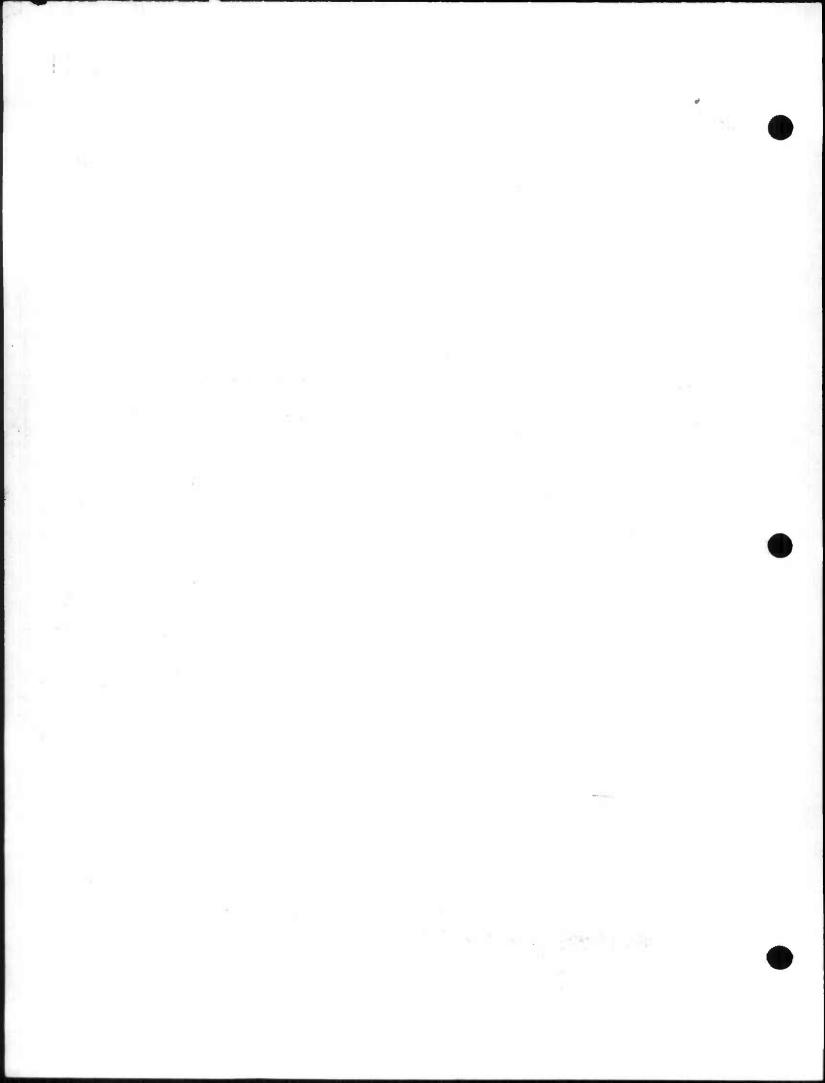
31. DATE FILED (Month,

NOV 1

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2 MEDICAL EXAMINER: On the basia of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 900 Bestgate Road, Ste. 300, Bestgate Rd. Ann. MD 10415

29c. LICENSE NUMBER

H3608



SC BALTIMORE, MARYLAND 21215-0020	within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	pletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, cremation, or removal.	rent, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Ibe filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Pages 1, 2, 3 should

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

" REGISTRA	H		CERTI	FICALE	OF DEATH	H	EG. NO.			
1. OECEOENT'S N	SALL	AKA Sa	rah EB	LIN	IE	2. DATE OF I	DEATH DAY EMBER 13	YEAR	102200 M	
4. SOCIAL SECUI	- 7693		AYS HOURS MIN.		25,1908	1908 MARYLAND 9c. COUNTY OF DEATH				
	ST HOSPITA			9b. CITY, TO	RANDALLS		100	BALTIMORE		
NORTHWE. RESIDENCE 10e. STATE MARYT.ANI	10a. STATE 10b. COUNTY 16 BAT.TTMORE				LOCATION TIMORE			I. INSIDE CITY LIMITS? YES 2 X NO		
					10f. ZIP CODE		10g. CIT	IZEN OF WHAT		
11. MARITAL STA	ed 2 Married	12. WAS DECEDENT ET FORCES? 1	YES 2 NO	H y	21208 S DECENDENT OF HISPA ea, specify Cuban, Mexic YES 2 XNO Speci	an, Puerto Ricai		USA 14. RACE — I Black, Wh Specify:	American Indian,	
O L	Elementary/Secondary (0-12) College (1-4 or 5+) IIIe. Do NOT				UPATION ing most of working	ROS	IO OF BUSINESS/ING ENBERG DY & TOBA			
17. FATHER'S NA	ME (First, Middle, Last)			RETARY	18. MOTHER'S N		le, Maiden Surname)	1000_0		
W NAT	'S NAME (Type/Print)			NBERG	RE Street and Number or Rural	BECCA	City or Town Ctate 7i	UNKNOW	WN	
	GLAS EBLIN	E			LL LANE BA					
4 Donation	206. METHOD OF DISPOSITION AC Burlel 2 Cremetion 3 Removal from State 4 Donestion 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of commeter), crematory or other place) DRUID RIDGE — 11–15+1995 PIKESVILLE, MD 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC.									
	ist conditions, to immediate UNDERLYING lase or injury	b. OUE TO (OF	TLO LO LC R AS A CONSEQUENCE R AS A CONSEQUENCE	E OF):	VEUMON) /A-			Onset and Death	
PART II. Othe	r significent condition	ne contributing to de	ath but not resulti	ng in the und	eriying cause given in		e. WAS AN AUTOPSY PERFORMED?	CO OF	THE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH?	
DID TOBA	ACCO USE CONT	RIBUTE TO CAUS				IN E			10	
25. WAS CASE R EXAMINER? 1 YES 2	EFERRED TO MEDICAL	HOSPITAL:		OTHER:		a [] au				
27. MANNER OF	DEATH 5 Pending	28a. DATE OF IN. (Month, Day,	JURY 286.		eg Home 5 Residence 8c. INJURY AT WORK? 1 YES 2 NO	7	IBE HOW INJURY OC	CURED		
2 Accident Investigation 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, streel, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							e Number,			
4 Homicid 29e. CERTIFIER (Check only one)		SICIAN: To the best of my							nd manner as stated.	
296, SIGNATURE	AND TITLE OF CERTIF	ER	lin		29c. LICENSE N	733	679	TE SIGNED (MO	Onth, Day, Year) R (), 9)	
	- RAVI		HC, Ba	Type, Print) Ltimo	ve Mo	2113	3			
31. DATE FILED (Month, Day, Year) / 1 6 1005	92. REGISTRAP'S	S SIGNATURE						DHMH-18 Rev 1/89	

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NOVE & STATE OF A LYDY

Item9a 11-16-95 FilmG729 W.H.Per F/H

Item31 See Item32 Per F/R

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF					ITAL HYGIENI REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	A F	OSTE	R			N 10	DATE OF DEATH DA	1 199	AB	1615 M
	4. SOCIAL SECURITY NUMBER 217 22 36 21	5. SEX 8. AGE (In)	yrs. last birthday) YRS.	IF UNDE	DAYS	IF UNDER 24 HOURS	HRS. 7. E	ATE OF BIRTH	8.		CE (State or Foreign
OR	90. FACILITY NAME (If not institution, give st	Sinai Hos	spital			R LOCATION MOTE	OF DEATH		9c. COUNTY	OF DEATH	1
Baltimore RESIDENCE OF DECEDENT 100. STATE MARYLAND N/A BALTIMORE									I. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	N/A		BAT.	101.	ZIP CODE			10g. CITIZEN		X YES 2 NO
FUNERAL	4110 Belvieu A		10 101150	1			215			USA	
BY					If yes, spe		Mexican, Pu	RtGtN? (Specify Yee erto Ricen, etc.)	or No.— 14.	Black, Wh	American Indian, hite, etc. Black
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondery (0-12) 8th	CATION 1 completed) College {1-4 or 5+}	(Give kind of life. Do NOT u	work done sa retired.)	during mos	IN st of working		Day C		Provider	
	17. FATHER'S NAME (First, Middle, Last) John Autry							irst, Middle, Maiden	Sumame)		
TO BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRES	S (Street e			Gibson Number, City or Town	, Stete, Zip Cod	de)	
F	Harrison Foste							Balti			
	1 Buriel 2 Cremetion 3 Remo	rvnt rom State	ery, cremetory or o	of DISPO other place Val	Llev	Mem.	1/16/ Gro	dn. Tim	CATION — City	or Town,	rvland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSKE) OU	ell	- ²²	ERO	Y O.	DYE!	TT & SO HEIGHT	N FUN	ERAI	L HOME
	23. AAFT Fin or the disease of cook, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	complications that cause it List only one cause of acc	th ilne.	not ente							Approximate Interval Between Onset and Daath
NO	Sequentially list conditions,	OUE TO (OR AS A C	culos	SU							WEEKS
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C									
SERT	resulting in deeth) LAST	d									
CAL	PART II. Other significent conditions	e contributing to deeth but	not resulting	in the u	inderlying	g ceuse giv	ren In Part	i. 24n. WAS AN PERFOR	MED?	COI	RE AUTOPSY FINDINGS MLABLE PRIOR TO MPLETION OF CAUSE DEATH?
N: MED	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	DEATH Y	ES 🗆	NO [UNCE	RTAIN ,	ৱ		1[YES 2 NO
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	S. PLACE OF OEA	OTHE							
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpati	26b. TII	AE OF	28c. tNJ	URY AT		Other (Specify) I. DESCRIBE HOW t	NJURY OCCUR	ED	
Natural 5 Pending M 1 YES 2 NO Investigation								5 15 1			
TED	3 Suicide 6 Could not ba 4 Homicide determined	building, etc. (Specify	- At nome, term,	Straet, for	стогу, опіс	•	261	. LOCATION (Street & City or Town, State)	ind Number or	Hurel Houte	Number,
COMPLET	one)	CtAN: To the best of my knowled R: On the basis of examination of								euse(e) end	d manner ee stated.
H	29b. SIGNATURE AND TITLE OF CERTIFIER	mD				ASZL	SE NUMBER	7.1-Star19	D 111	IGNEO (No	onth. Day. Year)
5	30. NAM AND ACCORESS OF PERSON WHI	O COMPLETEO CAUGE OF OEAT	14 (ITEM 27) (Typ)	Print)	Sin	Millas	pith	L, BA	-70	mi	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TIPE A				-		1		

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

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DIVISION OF VITAL RECORDS, P.O. BOX 6876	: HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wi
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First 3. TIME OF OEATH Novembe 520 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) APRI 22 8. BIRTHPLACE (State or Foreign DAYS HOURS ADRIL 1 - M 2 XF VA funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (if not institution, give street and number, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HOSPIT TIMORE NA SINAI DIRECTOR RESIDENCE OF D EDENT 10d. INSIDE CITY
LIMITS?
1 VES 2 NO 10c. CITY, TOWN OR LOCATION MI NA ALTIMORE FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? ROAD 21207 4001 CHATHAM USA 13. WIRS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)
1 YES 2 NO Specify: eath. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. AMMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, stc. 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced ACK ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INCUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5 +) フャル COMPL NA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) WOOTEN AMES MINNIE DNTAINE notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zip Code 2 Ortie hat Md 21207 pe 20e METHOD OF DISPOSITION
1 N Burlet 2 Cremetion 3 Removal from State
4 Ocnetion 5 Other (Specify) PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must demelary, crematory or other place) mills, md examiner 22 NAME AND ADDRESS OF FACILITY
HARCH FUN ERAC 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hd. 21215 Dalto. completely filled in by the medical 23. PART 1. Enter the biseesee, or complications that caused the death. Do not enter the ahock, or heart fallura. List only one cause on each line. Approximate Interval Between cremation, or IMMEDIATE CAUSE (Final **Onset and Death** other traumatic event, the disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) and com bunial, o CERTIFICATION Sequantially list conditions, prior to l if any, leading to immediate cause. Enter UNDERLYING this certificate has been signed by the attending physician with the State Dept. of Health and Mental Hygiene prior to CAUSE (Disease or injury IUE TO JOR AS A CONSEQUENCE OF that initiated eventa resulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL OTHER:
4 Nursing Home 5 Residence 1 | Inpatient 2 | ER/Outpatient 3 | DOA 10 27. MANNER-OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 2 NO BY FUNERAL DIRECTOR: After within 72 hours after death Investigation 2 Accident 26e. PLACE OF INJURY - At home, term, street, lectory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town State) 28 is 3 Suicide 8 Could not be COMPLETED 4 Homicide determined item ; 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) and menner ee stated. IMPORTANT: IF 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date end piece, 29h SIGNATURE AND 29c. LICENSE NUMBER 29d. DATE SIGNED (Month BE 開出 M 22 4 5 2 2 3 9 COMPLETED CAUSE 6 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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31. DATE FILED (Month, Day, Year) NOV1 6 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ROBERT FINE, M.D. NORTHWEST

Julia Mudlan Radell

NONTIMEST

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

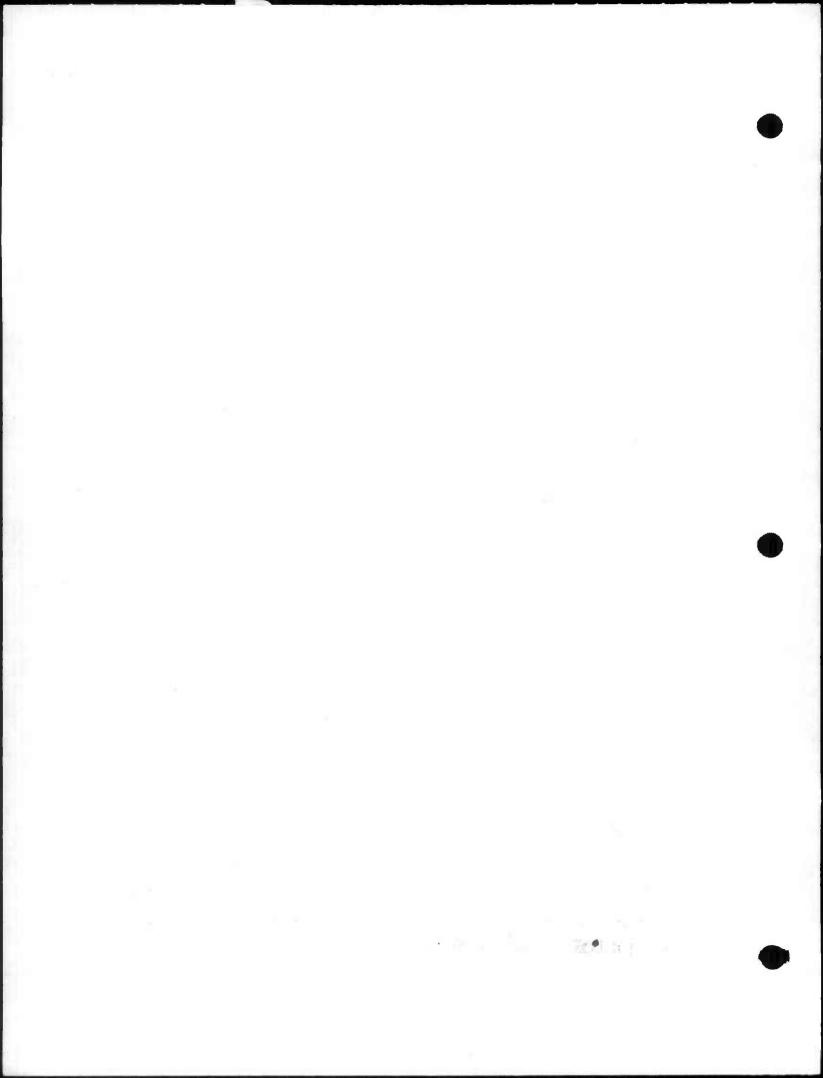
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	FOR STATE REGISTRAR	STATE OF N	MARYLAND /				IEALTH DEAT			YGIENE EG. NO.			
	1. DECEOENT'S NAME (First, Middle, Last)								2. DATE OF C	EATH			3. TIME OF DEATH
	SAMAH	F	PANKE						MONTH NOVEM	DAY		YEAR	25ZA
	4. SOCIAL SECURITY NUMBER	5. SEX	B. AGE (In yrs. las	t hirthrian)	IF UNDER	B 1 VEAD	IF UNDER	24 MBC	7. DATE OF B		15	995	PLACE (State or Foreign
	054 30 5000	1 M 2 F	94	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day	(Year)		Country)
	064-10-6882		17	ino.		<u></u>			JAN.	2,19			V YORK
~	Se. FACILITY NAME (If not institution, give s				9b. CITY	Y, TOWN (OR LOCATIO	ON OF DE	EATH		9c. COU	INTY OF DE	EATH
0	NORTHWEST HOSPITA	L CENTER				RAN	DALL	STOW	N			BALTI	IMORE
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v		T 40 - 017	Y, TOWN	00.1001							
<u> </u>				100. 011	i, lown							1	10d, INSIDE CITY LIMITS?
		N/A					TIMO						1 YES 2 NO
FUNERAL	3028 FALLSTAFF RD	., APT. 2	2-C			101	2120 2120					USA	HAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MEO	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Sp	ecify Yes	or No	14. RACE	- American Indian,
BY F	1 Never Merried 2 Married	IF YES, GIVE W	AR OR DATES	10			2 X NO		n, Puerto Rican	, etc.)		Specifi Specifi	, White, etc.
	3 Widowed 4 Divorced						Α						WHITE
9	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON ast of workin	0	16b. KINI	OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 8 +	- Elle	Do NOT us	se retired.)	during mo	at or worter	¥					
릴	8		H	OUSE	WIFE				OWN	HOME	7		
COMPLET	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	IER'S NAI	ME (First, Middle				
ш	OSIAS		KE	SLIN	GER			SABTI	NIA.			REIF	FLER
8	19a. INFORMANT'S NAME (Type/Print)					S (Street a			Route Number, C	ity or Town	, State, Zij		
유	MRS. BLANCHE	AGETSI	EIN 3	028	FAL	LSTA	FF RI	D., i	APT. 2-	-C B2	AT.TT	MORE.	MD 21209
	20a. METHOO OF DISPOSITION	-072_555	20b. PLACE	ANDDATE	-							City or Toy	
Ш	XX Burial 2 Cremation	oval from State	cemetery, cre	metory or o	ther plece)	D 173	O T ISIZ 7		Thur or			4 0=	MASPETH NV
	21. SIGNATURE COTUNERAL SERVICE LIE	ENTEE	PIL a Zi	TON	22.	NAME AP	ND ADORES	SS OF FAC	CILITY			4-95-	MASPETH, NV
H	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	5-	-)						& BROS				
\square	1 11/	Jusa	en		60	010	REIST	ERS!	POWN RO	DAD E	BALT:	IMORE	, MD 21215
	23. PART I. Enter the diseases or a shock, or heart fellure.	complications that	t caused the de	ath. Do r	not enter	r tha mo	da of dyl	ng, aucl	h aa cardlec	or reapir	atory ar	reat,	Approximata
	IMMEDIATE CAUSE (Final												Intarval Batween Onset and Death
	disease or condition resulting in death)	DUE TO AMERICA	E MYO	CAN	DIA	L 1	NFAI	RCTI	ON				2 HOURS
		DUE TO	OR AS A CONSEC	DUENCE O	F):								
z		A ANTER	-105LL	ERON	-	HE	THE	DI	SCASE				YEARS
일	Sequentially list conditions, if any, leeding to immediate	DUE TO	OR AS A CONSEC	DUENCE O	F):								
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	c.											
ERTIFICATION	thet initiated events	DUE TO	OR AS A CONSEC	DUENCE O	F):								
	reaulting in death) LAST	d											
5	DART II Onto a la lilla da ca allala											-	
الجا	PART II. Other algnificant condition	a contributing to	daath but not r	eaulting	In the ur	nderlyln	g ceuse g	liven in	Part I. 24s.	WAS AN A		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
8								_	1 [YES 2	XNO.		COMPLETION OF CAUSE DF DEATH?
MEDICA													1 _ YES 2 _ NO
ä	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆	NO [UNC	ERTAIN	NE				
¥.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEA		_							
Sic	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHEI		e 5 🗆 Re	sidence	8 Other (Spe	icifv)			
PHYSICIAN:	27. MANNER OF OEATH	28a. DATE OF		28b. TIM	E OF	28c. INJ	URY AT		28d. OESCRIB		JURY OC	CUREO	
ВУР	1 Natural 5 Pending Investigation	(Month, De	ny, rear)	IN.	IURY M		RK? (ES 2 _	NO					
	2 Suiside	28e. PLACE O	F INJURY — At ho	me, tarm, :	street, fac	tory, offic			281. LOCATION	(Street ar	nd Numbe	r or Rural Re	oute Number.
E	4 Homicide S Could not be	building,	atc. (Specify)						City or Tov	vn, State)			
Ш	29a. CERTIFIER	CIANI. To All I have a									-		
COMPLETED	(Check only												
8			semmenton and/or i	rivestigatio	on, in my o	opinion, d	eath occur	ed at the	time, date and	place, and	due to ti	he cause(a)	and manner as stated.
ш	296. SIGNATURE AND TITLE OF CENTURE	4					29c. LICE						(Month, Day, Year)
0 8	Muy						D	175	-87		1	OVEM	Bon 12,1915
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALL	E OF DEATH STEE	4 27) /T	(Defect)								

HSPITAL CENTER

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		CERTIF	ICALE OF	DEATH	A	EG. NO.			
Ī	1. DECEDENT'S NAME (First, Middle, Last) Samuel Hugh Gori	don				2. DATE OF I	D/		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Octobe 7. DATE OF E	HOTH			9:05 p M LACE (State or Foreign
	215-03-3027	1X M 2 F	84 YRS.	MONTHS DAYS	HOURS MIN.	F & D.	8, 1	911	Marry	land
œ	9a. FACILITY NAME (# not inattution, give str 141 East Main Str	,		96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF I WESTMENSTER Carroll						ATH
DIRECTOR	RESIDENCE OF DECEDENT			WOSCHIC				Car		
出	10a. STATE 10b. COUNTY Maryland Carro	00		r, town on Loca tminste					1	Od. INSIDE CITY LIMITS?
١٦	10e. STREET AND NUMBER		wes		f. ZIP CODE		_	40- 017		TAT COUNTRY?
FUNERAL	141 East Main Str				21157			iug. Ci ii	U.S.	
	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EV FORCES? 1	YES 2 X NO	If yes, s	CENDENT OF NISPAN Decify Cuban, Maxica	n, Puerlo Ricar	pecify Yes n, etc.)	or No-	14. RACE - Black,	- American Indian, White, etc. White
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	1 🗆 YE:	2 X NO Specify	y:			Specify:	white
H	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION completed)	16e. DECEDENT'S (Give kind of	USUAL OCCUPATI york done during m e retired.)	ON ost of working	16b. KIN	D OF BUS	INESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		r/Exped		BA	ack	and	Decke	ħ
OM	17. FATNER'S NAME (First, Middle, Last)		000000	07 6 70 600	18. MOTHER'S NA				7 00100	
SE C	Thomas Hugh Gordon				Fannie					
TO BE	190. INFORMANT'S NAME (Type/Print) Will Shirley Gordon	6e	19b. MAILING 1 1 1 F	AODRESS (Street	and Number or Rural I	Route Number, C	Hy or Town	n, State, Zip	Code)	nd 21157
	20a. METNOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remov		20b. PLACE AND DATE	F DISPOSITION (N		OATE			City or Town	
	4 X Donation a □ Other (Specify)		cametary, cramatory or of	10.000		1				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE RONald Wade, Dir. State Anatomy Board-655 W. Baltimore Street									
	Juneal/III	de 1	1/15/93		26-Baltin					1-1559
	23. FART I. Enter the disasses, or co shock, or heart fallure. L	at only one cause of	used the death. Do r on each line.	ot enter the mo	oda of dying, auc	h aa cardiec	or reapli	ratory arr	eat,	Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition	Seccis								Onset and Death
ı	resulting in death) a	DUE TO (OR	AS A CONSEQUENCE OF):						Days
NO	Sequentially list conditions,	11 eumon	AS A CONSEQUENCE OF							weeks
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	Immob.	Tity Synd	rome						Weeks
Ē	riler lilitatod exelles									
H	resulting in deeth) LAST	Kadia	ion Eteri	HI						Minths
	PART II. Other algnificant conditions	contributing to dea	th but not reaulting i	n the undarlyin	g cause given in	Part I. 24s	WAS AN			PERE AUTOPSY FINDINGS
EDICAL	Projete Car P Deme	icer, Ka	diation f	roctitis	/	10	YES 2		C	VAILABLE PRIOR TO OMPLETION OF CAUSE IF DEATH?
Σ	1 Denc	ntiq				_				☐ YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTR	BUTE TO CAUS	28. PLACE OF DEAT		UNCERTAIN	1 🗆				
SICI	EXAMINER?	HOSPITAL:		OTHER:	ne 5 Residence					
ξ	27. MANNER OF OEATH	28a. DATE OF INJU	JRY 28b. TIM	OF 28c. IN.	URY AT	28d. OESCRIE		JURY OCC	URED	
BYF	1 Natural 5 Pending 2 Accident Investigation	(MONIN, Dely, Te	ind)		PRK? YES 2 NO					
	3 Suicide & Could not be 4 Nomicide determined	28s. PLACE OF IN. building, atc.	IURY — At home, lerm, a (Specify)	treat, factory, offic	•	28f. LOCATION City or Tox	N (Street a	nd Number	or Rural Rou	ite Number,
<u> </u>	29a. CERTIFIER			New York						
COMPLETED	(Check only one) 2 MEDICAL EXAMINER.		nowledge, death occurre							nd manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIED				29c. LICENSE NUM					fonth, Day, Year)
O BE	41 h. Blok	MI MI	2		D333	20		> /	1/7	195
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF	-		11.0.			9		
	F.M. Gloth, II MD 201 E. University PKWY 21218									
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S			7					



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BOX 68760,	law requires that the death certificate be executed within
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DIVISION OF VITAL RECORDS, P.O.	TAL OR ATTENDING PHYSICIAN: The I
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First										2. DATE	OF DEATH	NA.	YEAR	3. TIME OF DEATH	
	Anthony		rioso									ember			0850 AM	
	4. SOCIAL SECURITY NUMI	BER	5. SEX	6. AGE (Ir	n yrs. last bi		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE (OF BIRTH , Day, Year)	004	8. BIRTH	IPLACE (State or Foreign	
	219-01-5096		1 🔀 M 2 🗆 F		74	YRS.		ONTHS DAYS HOURS MIN. OCTOBER 8, 1921 Mary Label 1921 OCTOBER 8, 1921 OCTOBER 1921								
ا ي	9a. FACILITY NAME (If not in		treet and number)			18				ON OF DI	EATH			NTY OF D	EATH	
DIRECTOR	St. Agnes H							ltim	ore				N/A			
ည္က	10e. STATE	10b. COUNTY	1	IOc. CITY,						***			10d. INSIDE CITY			
5	Maryland	Balti	more				Е	Balt	imore	9					LIMITS?	
¥	10e. STREET AND NUMBER							10	. ZIP COD	-	10g. CITIZEN				WHAT COUNTRY?	
FUNERAL	2500 Gehb Ave	nue							212	227						
בו בו	11. MARITAL STATUS 1 Never Married 2 🔀	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yell for the specify Cuban, Mexican, Puerlo Rican, etc.)						or No-	14. RACI	E — American Indian, k, Whita, etc.						
B	3 Widowed 4 Divo				2 📉 NO			,		Spec						
	15. DEC	SUAL O	CCUPATIO	ON		16b.	KIND OF BUS	INESS/IN	DUSTRY	WILL CO.						
COMPLETED		ly highest grade 0-12)		+)	(Give	kind of wo NOT use	retired.)	during mo	st of working	ng						
린	Elementary/Secondary (0-12) College (1-4 or 5 +) Machinist										AT&T					
Ő.	17. FATHER'S NAME (First, N								18. MOTHER'S NAME (First, Middle, Maid Hilda Battaglia				Surname)			
BE	Anthony S. Gl								Hilo	la Ba	ttagli	a				
2	Gloria Ament		ter)									e, Mary				
	20a. METHOD OF DISPOSIT				PLACEANE			ITION (N	ame of		DATE	20c. LO	CATION -	City or To	own, State	
	1 🛱 Buriat 2 🗆 Crematic 4 🗆 Donation 5 🗆 Other	tory or other	1 Cemetery Nov. 18, 1995 Baltimore, Maryland						yland							
	21. SIGNATURE OF PUMERA	L SERVICE LIC	ENSEE	1			22. Le	NAME A	M. ADDRE	SS OF FA	ilite.	Witzke	Funer	al Ho	mes	
	Dusce	ucu) its	0												
	23. PART I Enter the diseases, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate															
- (snock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine)												Intarval Between Onsat and Daath			
	disease or condition	\rightarrow	Seps												24 hrs	
					CONSEQUE											
O	Sequentially list condit		-		nbran			1t18	5						3-5 days	
A	If any, leading to imme cause. Entar UNDERLY	ING		Care 1 25 1 1											j	
RTIFICATION	CAUSE (Diseasa or Injuthat Initiated evanta		DUE TO	(OR AS A	CONSEQUE	ENCE OF):										
ERI	resulting in death) LAS	T .	d													
CE	PART II. Other algolitica	ant condition	s contributing to	death bu	it not read	ulting in	the un	derivin	a cause	alven In	Part I.	24s. WAS AN	AUTOPSY	245	. WERE AUTOPSY FINDINGS	
EDICAL	=											PERFOR	MED?	1	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
입			*								-	1X YES 2	NO		DF DEATH?	
2	DID TOBACCO	O USE C	ONTRIBUTE	TO C	CAUSE	OF	DEAT	ΉY	ES 🖂	NO	TX				1X YES 2 NO	
A P	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL						28. PI	ACE OF D	EATH (Ch	eck only on	e)				
PHYSICIAN:	1 TYES 2 NO		HOSPITAL:	ER/Outpe	itlant 3 🗆		OTHER		10 5 R	rsidence	6 Other	(Specify)				
E	27. MANNER OF DEATH		28e. DATE OF (Month, L		2	8b. TIME			URY AT		28d. DEŞ	CRIBE HOW II	NJURY OC	CURED		
B		Pending Investigation					М	1 🔲	YES 2	NO						
		Could not be detarmined	28a, PLACE C building,	etc. (Specif	— At home,	, term, str	oot, fact	ory, offic				ATION (Street a or Town, State)	ind Numbe	r or Rural i	Route Number,	
H.						=										
COMPLETED	(Check only		CIAN: To the best of												and second waters	
8				xamination	and/or Inve	estigation,	, In my o	pinion, d	leeth occu	red at the	time, date	and place, an	d due to t	he cause(s	s) and manner ea stated.	
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ye)																
2 │	30. NAME AND ADDRESS O	F PERSON WH	O COMPLETED CALL	SE OF DEA	TH OTEM ?	7) (Time 5	Print)		D08	949			No	vemb	er 14, 1995	
									00 0	a to = :	A		1			
	Bert F. Mor	OR Ju	A MAGISTA	H'S SIGNA	TURE	osh1	LdI	- 9	UU U	aton	Ave	<u>- ва</u>	ltim	ore.	Md. 21229	
	MUNI PIS	22 0.														

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BALTIMORE, MARYLAND 21215-0020	h certificate be executed with nours after death. Page 6 may be retained by the hospital or attending physician.	anding physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per
9	ing	the
15	tend	35
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P.O. BOX 68760	Kecut	anding physician and completely filled in by the
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	tifici	do C
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Π.	-	E "

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE O	F DEATH		. NO.				
1	1. DECEDENT'S NAME (First, Middle, Las	R. 608	IleR			2. DATE OF DEA		YEAR 3. TIME OF DEATH			
1-9	4. SOCIAL SECURITY NUMBER 215 - 6 6-3661	5. SEX 6. AGE	(In yrs. last birthday) 40 YRS.	IF UNDER 1 YEAR MONTHS DAY		7. DATE OF BIRT (Month, Day, Y	11/53	BIFTHPLACE (State or Foreign Country) Balt) Mou			
CTOR	9a. FACILITY NAME (If not institution, give MCLCY HOSATTAL) RESIDENCE OF DECEDENT	Balt 14N/	UD	Baly	N OR LOCATION OF DE	MD	9c. COUNT	V OF DEATH			
DIRE	MARYLAND 10b. COUN	N/A		Y, TOWN OR LO				10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	3323 E. BALTIMORE				101. ZIP CODE 21224		EN OF WHAT COUNTRY?				
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 N Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 Tyes IF YES, GIVE WAR OR I	2 ZNO	It yes,	DECENDENT OF HISPAN, specify Cuben, Mexica (ES 2 ANO Specify	C ORIGIN7 (Specify Yes or No— Puerto Ricen, stc.) 14. RACE — American Indian Bleck, White, stc. Specify: WHITE					
COMPLETED	15. DECEDENT'S ET (Specify only highest gra Elementery/Secondary (0-12) 10 YEARS		18e. DECEDENT'S (Give kind of life. Do NOT us	work done during se retired.)	ATION most of working		SELF EMPLOYED				
	17. FATHER'S NAME (First, Middle, Last) ROBERT GOELLER				18. MOTHER'S NA GERTRUDE		,				
TO BE	190. INFORMANT'S NAME (Type/Print) MR. CALVIN GOELLI	TR		MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 RIVERVIEW ROAD BALTO, MD. 21221							
	200. METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 200. PLACE AND DATE OF DISPOSITION (Name of CHARLET FRY CFM. 11-18 BALTO. MI										
	21. SIGNATURE OF FUNERAL SERVICE	CON SANTUI	ski	22 NAME 2525	OROWSKI FU FLEET ST	NERAL H BALTO	IOME MD. 212	222			
MCAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASC DUE TO (OR AS	A CONSEQUENCE O)F):	ial in	Farcl	in	1 ln yeare			
MEDICAL C	PART II. Other eignificant conditi	ons contributing to death	but not resulting	in the underly	ying ceuse given in	PI	AS AN AUTOPSY ERFORMED? YES 2 10	24b. WERE AUTOPSY FINI AWAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28 OTHER:	. PLACE OF DEATH (Ch	eck only one)					
РНУ	1 PYES 2 NO 7 27. MANNEP OF DEATH 1 Natural 5 Pending Investigation	1 Inputient 2 PER/Ou 28e. DATE OF INJURY (Month, Day, Year)	28b. TIN	ME OF 28c.	INJURY AT WORK? YES 2 NO		HOW INJURY OCCU	PRED			
ETED BY	2 Accident investigation 3 Suicide 8 Could not b 4 Homicide determined	284 PLACE OF IN HIS	RY — At home, farm, ecify)			281. LOCATION (S City or Town,		r Rural Route Number,			
COMPLE	one)	/SICIAN: To the best of my kno NER: On the basic of examinati									
O BE C	29b. SIGNATURE AND TITLE OF GERTIF	buly 1	1.0		29c. LICENSE NUN	1943	29d. DATE	SIGNED (Month, Day, Year)			
Ţ	30. NAME AND ADDRESS OF PERSON OF	WHO COMPLETED CAUSE OF D	M, D.	9. Print) ME.	2 cy HOS 81	tal st.	baltix	ne UD			
	NOV1 6 1995 Jul	A2. A GISTR S SI	NATURE								

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or artending physician,	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should thin State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	ENE
		CE	RTIFICATE	0	F DEAT	H		REG	NO

	REGISTRAR		CERTIFI	CATE	OF DEA	I H		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH		MEAN	3. TIME OF DEATH
	HOLLIS C		HELTZEL				NOVEM	BER T	1, 1	995"	5:35 A
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER	1 24 HRS.	7, DATE OF		25	8. BIRTH Countr	PLACE (State or Foreign
	224-28-5623	1 🕅 M 2 🗆 F	70 YRS.	months (M	HOURS	mile.	Feb.	12,19	23		GINIA
_	9e. FACILITY NAME (If not institution, give s				WN OR LOCATI		EATH			NTY OF D	
0	VAMICSFORT HOWA	ARD DIVISIO	N	FORT	HOWAR	D			BAL	TIMO	RE
ច្ច	RESIDENCE OF DECEDENT 100. STATE 10b. COUNT	1	ine city	, TOWN OR L	CATION						
- DIRECTOR	Maryland	N/A	100. 011	Baltimore City							10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 2717 Fait Avenue	e			101. ZIP COD		1224		10g. CITIZEN OF WHAT COUNTY United State		
ا جَ	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 💢	ER IN U.S. ARMED	13. WAS	DECENDENT (OF HISPAI	NIC ORIGIN?	Specify Yee	or No-	14. RACE	- American Indian, White, etc.
B	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR O	R DATES	1 🗆	s, specify Cube YES 2 XNO	Specif	en, Puerto Rice ly:	in, etc.)		Speci	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Coflege (1-4 or 5 +)	16a, DECEDENT'S	ndk done durin	PATION g most of working	ng	16b. KJ	ND OF BUS	INESS/IN	DUSTRY	
립	Unknown	contage (1-4 of 5 +)	Army Co	האטטאמ	Р.			Fodo	ral (Gauge	inment
ō	17. FATHER'S NAME (First, Middle, Last)	·		90000		HER'S NA	ME (First, Mide			0000	Crun Cru
	Unknown					lice		ler			
8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str			1.00		State Zie	Code)	
임	Thelma Navratil		3130 Fa								224
			20b. PLACE AND DATE O	FDISPOSITIO	M (Name of		DATE	200 100	ATION	City of To	was State
	20e, METHOD OF DISPOSITION KLZ Burlet 2 Cremation 3 Removal from State 4 Donalion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of commettery, prematory or other place) LOUGON PAIR CEMETERY 11/14/1995 Baltimore										MD
	21. SIGNATURE OF FUNERAL OCCUCENSEE LOUGON Park Cemetery 11/14/1998 Baltimore, 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundal										
	= 101			792	a-Ruck 2 Wise	tun	eral H Dun	lome (idalk.	of Do	undal 212	Ck, Inc.
	23. PART I. Enter the diseases, or o	complications that cau	ised the death. Do n	ot anter the	mode of dy	ing, suc	h as cardiec	or respir	atory an	rest,	Approximata Interval Batwee
	ahock, Dr haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final										
	disease or condition resulting in deeth) a. LUNG CANCER										
	DUE TO (OR AS A CONSEQUENCE OF):										2 YEARS
z		b.									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR /	AS A CONSEQUENCE OF):							
5	CAUSE (Disease or Injury	c									
=	that initiated events resulting in death) LAST	DUE TO (OR /	AS A CONSEQUENCE OF):								
1	resulting in death) Exst	d,									
- 11	PART II. Other significant condition	e contributing to deat	h but not regulting in	the under	ving cause i	alven in	Pert I. 24s, WAS AN AUTOPSY		1 000	WERE AUTOPSY FINDINGS	
SA					July Couse !	given in	7 61(1.	PERFORI		240.	AWAILABLE PRIOR TO COMPLETION DF CAUSE
בַּ							1	YES 2	NO		OF DEATH?
Σ	DID TORACCO LICE CONTE	NOUTE TO CALLE	OF DEATH AND	. 657							1 TES 2 NO
2	DID TOBACCO USE CONTI	RIBUTE TO CAUSE				ERTAI	и Ц Т				
<u> </u>	EXAMINER?	HOSPITAL:	26. PLACE OF DEATE	OTHER:	one)						
PHYSICIAN:	1 TYES 2 NO	1X Inpetient 2 ER/	Outpatient 3 DOA	4 - Nursing	Home 5 Re	eldence					
	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Ye		IRY	INJURY AT WORK?	. 15	28d. DESCR	BE HOW IN	JURY OC	CURED	
à	2 Accident Investigation	20- 57-22-22-22			YES 2	NO					
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJ building, etc. (URY — At home, lerm, st Specify)	reel, lactory, (office		281. LOCATIO	ON (Street er own, Stete)	nd Number	or Rural R	oute Number,
29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end manner se stated.											
5	one) 2 MEDICAL EXAMINE										end menner ee stated,
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER					NSE NUN					
4	Mary Just	Zi ins				56	65			JA V	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	Print)	111	20	15		- /		11,177
	MARCOS GALICIA. M	D9600 N	ORTH POINT		FORT	HOW	ARD, M	ARYLA	ND 2	21052	
	31. DATE FILED (Month, Day, Year)	32. AGGISTRAP'S S	MENATURO CAROLLA								
	WIIV I E NEW	1	400.000.000								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year) NOV 1 6 1995

CH3:	23	PARI	Τ,	PER	DK.	LIFM	U-729	11/10/95	τ.τ
115/19									

110.0. 20 1 1, 12.	N DN TIEN U-72	.5 11/10/55 €				
FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN REG. NO	_	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH
A 3320E		-Z6G		MONTH D	1:35 a m	
4. SOCIAL SECURITY NUMBER 579-16-8369			UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 05-26-19	Country	PLACE (State or Foreign D.O hington,
9a. FACILITY NAME (If not institution, give st	reet and number)	9b	CITY, TOWN OR LOCATION OF D	EATH	9c. COUNTY OF D	EATH
Meridian Multi-	-Med		Towson		re	
10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATION		1	10d. INSIDE CITY
Md.	N/A	Balt	imore		LIMITS? 1XX YES 2 NO	
10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF V	HAT COUNTRY?
1032 Valley St	reet		21202		U.S.	Α.
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 X NO	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Maxico 1 YES 2 X NO Specifi	en, Puerto Ricen, etc.)	Spec/	— American Indian, t, White, etc. ty: i te
15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S US	UAL OCCUPATION	16b. KIND OF BU	SINESS/INDUSTRY	
(Specify only highest grade	completed)	(Give kind of work life. Do NOT use re	done during most of working otired.)			
Elementary/Secondary (0-12)	College (1-4 or 5+)			Jackinst	Timos	2 Dogt
		Advertis			ton Times	a Post
17. FATHER'S NAME (First, Middle, Last)			1	AME (First, Middle, Malder	Sumame)	
Moses Herzog			Minnie	e Wolf		- /
19s. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	ORESS (Street and Number or Rural	Route Number, City or Tov	vn, State, Zip Code)	
Lilly Thornton			alley Street, Ba			
20a. METHOD OF DISPOSITION 1	oval from State C8	b. PLACEAND DATE OF Commetery, crematory or other	ninosi	1/13/95 Ba.	CATION - City or To	
21. SIGNATURE OF FUNERAL SERVICE LIC		CCIMIOUITE	22. NAME AND ADDRESS OF F/		LCTINOT C 311	u•
· Indias	Alexand.		Lilly & Zeiler			1231 Avenue
23. PART I. Enter the diseases, pr	complications that cause	d the death. Do not				Approximate
	List only one ceuse on	eech Ilne.	9100	SEV.		Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition	_	-		Que		Oliset and Death
resulting in death)	Rose	nov	ory 1 ar		_	
	DUE TO (DR A	A CONSEQUENCE OF):	1			
	b.		1			
Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):				
cause. Enter UNDERLYING	ANOXIC ENCE	PHALOPATHY				
CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS	A CONSEQUENCE OF):				
resulting in death) LAST	CEREBROVASC	ULAR ACCIDEN	21			
	d	OLINI HOUTBEN	10			
PART II. Other algnificant condition	a contributing to death	but not resulting in	the underlying cause given in			. WERE AUTOPSY FINDINGS
pultiple o	allow	roalo	- Acceda	TO YES	RMED?	AVAILABLE PRIDR TO COMPLETION OF CAUSE
	0.0	-00		1 1 123	'X ***	OF DEATH?
A TORE	esperal	6			-	1 TYES 2 NO
DID TOBACCO USE CONTI	RIBUTE TO CAUSE (OF DEATH YES	NO UNCERTAI	IN DE		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH				
1 VES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out	tpetient 3 DOA 4	THER: Nursing Home 5 - Realdence	8 Other (Specify)		
27. MANNER OF DEATH	28a. DATE OF INJURY			28d. DESCRIBE HOW	INJURY OCCURED	
Natural 5 Pending	(Month, Day, Year)	INJUR	WORK? M 1 YES 2 NO			_ 1
2 Accident Investigation	28a DI ACE OF IN 111	IY At home, farm, atre		281, LOCATION (Street	and Number on Burni	Route Number
3 Suicide B Could not be 4 Homicide determined	building, atc. (Sp.		es, ractory, office	City or Town, State		nouse ITMITADOS,
290, CERTIFIER CERTIFYING PHYS	ICIAN: To the heat of my line	wlades death secured	at the time, data and place, and du	se to the cause(s) and -	anner se stated	
(Check brilly			in my opinion, death occured at th			a) and manner as stated.
29H SIGNATURE AND TITLE OF CERTIFIE)	29c. LICENSE NU	JMBER	29d, DATE SIGNA	(Month, Pay, Year)
Horo D	15.00	e .	M-DDZ	1680	P (1)	11/95-

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ((TEM 27) (Type, Print)

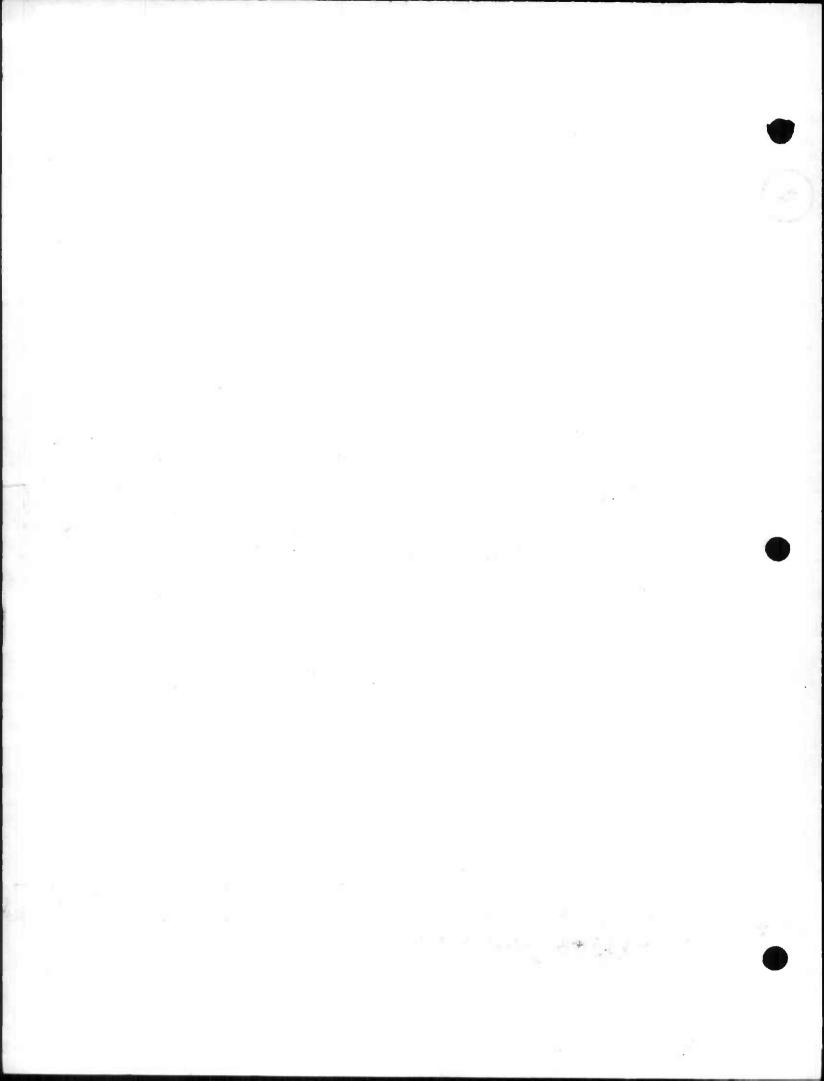
HOWARD B-EHEN, M-D-6717 PARK HE(6415)

of REGISTRAR'S SIGNATUSE



DHMH-18 Rev 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		MENTAL HYGIEN					
	DECEDENT'S NAME (First, Middle, Last) HELEN	D.			FFMAN	2. DATE OF DEATH DO NOVEMBER		3. TIME OF OEATH 10:45pm m			
	4. SOCIAL SECURITY NUMBER 5. 213-01-7499 1	8. AGE (In yrs.	YRS.	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) AUG. 28,	1911 M	IRTHPLACE (State or Foreign ountry) ARYLAND			
TOR	9a. FACILITY NAME (If not institution, give street 3601 CLARKS LANE, RESIDENCE OF DECEDENT		9		R LOCATION OF DE	ATH	9c. COUNTY OF DEATH N/A				
DIRECTOR	10a. STATE 10b. COUNTY	/A		TOWN OR LOCAT			10d. IL 1 🔀				
FUNERAL	3601 CLARKS LANE,	APT. 206		101.	21215		10g. CITIZEN OF WHAT COUNTRY? USA				
B∀	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN U.S., FORCES? 1 YES 2 IF YES, GIVE WAR OR OATES		If yes, spe	ENDENT OF HISPAN celfy Cuben, Mexica 2 X NO Specify		RACE — American Indian, Black, White, atc. Specify: WHITE				
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) 12		(Give kind of wor life. Do NOT use	SUAL OCCUPATION to done during most retired.)	st of working	16b. KIND OF BUS	SINESS/INDUST				
COM	17, FATHER'S NAME (First, Middle, Last) HARRIS	LEVY			18. MOTHER'S NA	ME (First, Middle, Maiden	Surname) HERMO	NT.			
TO BE	19a. INFORMANT'S NAME (Type/Print) MRS . ALENE	DAHNE		NG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1/2 UTAH STREET SAN DIEGO, CA 92116							
	20s. METHOD OF DISPOSITION 1 Deutle 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)										
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE Cattle	30			& BROS., : STOWN ROAD		ORE, MD 21215			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence op: b. Hyperlusium Character op: b. Hyperlusium Character op:										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c										
ERTI	that initiated evants resulting in death) LAST d										
PHYSICIAN: MEDICAL C	PART JI. Other significant conditions of CARCOLO MEGALY CANOLI OF BRICIA	Hyperlipiden	nia	Brlag	illal	PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 (1) NO			
IAN	DID TOBACCO USE CONTRIE	28. P	LACE OF DEATH		UNCERTAIL	иП					
YSIC	1 NES 2 NAO 1	OSPITAL: Inpatient 2 ER/Outpatient	t 3 🗆 DOA 4			8 Other (Specify)					
ву рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	WO WO	URY AT RK? (ES 2 NO	28d. OEŞCRIBE HOW	NJURY OCCURE	ED .			
G	2 Accident 3 Suicida 8 Could not be datarmined 28e. PLACE OF INJURY — At home, ferm, atrest, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPLET	One)	N: To the best of my knowledge On the basis of examination end						use(a) and menner as stated.			
TO BE C	296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNEO (Month, Dey, Year) 11-13-95										
7	30. NAME AND ADDRESS OF PERSON WHO CO	COMPLETED CAUSE OF DEATH ((ITEM 27) (Typo, F 63501	Print)	er Riv	BALTO	. 810-	21207			
	NUV 1 6 1995	32. REGISTRAR'S SIGNATUR	re.								

4. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	7120101711111				IOAIL	- OF	DEA	In		REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Last) BETSY COCKEY H	73 5737 7777							2. DATE OF MONTH	Di		YEAR	3. TIME OF OEATH
		AYNIE							NOVE	BER	10 .	1995	4:10 am
	4. SOCIAL SECURITY NUMBER 218-32-9329	5, SEX	6. AGE (in yrs. les	st birthday) YRS.	MONTHS	1 YEAR DAYS	HOURS	24 HRS. MIN.	Sept.	BIRTH by, Your)	1933	8. BIRTHI Country Marry	PLACE (State or Foreign
	9e. FACILITY NAME (If not institution, give :	street and number)			9h CITY	TOWN (OR L OCATA	ON OF DE		- ' '		OUNTY OF DEATH	
E E	GREATER BALTIMOR		CWNTED			T0117011							
DIRECTOR	RESIDENCE OF DECEDENT	E MEDICIE	CBNTBR		1000	JO14					BA.	LTIMO)KE
	10a. STATE 10b. COUNT	Υ			Y, TOWN O		TION						10d. INSIDE CITY LIMITS?
	Maryland			Ba	ltimo	re							X YES 2 NO
A P	10e. STREET AND NUMBER					101	. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	7118 Heathfield R	oad					2	1212			(I.S.A	
5	11. MARITAL STATUS	EVER IN U.S. AR	RMED	13. V	MAS DEC	ENDENT C	F HISPANI	IC ORIGIN? (S	pecify Yes	or No-	14, RACE	- American Indian,	
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	R OR DATES	NO			2 X NO		, Puerlo Rica	n, etc.)		Specif	- American Indian, White, etc., y: White	
		1											
COMPLETED	15. DECEDENT'S EOU (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S live kind of a Do NOT us	USUAL OC	CUPATIO	ON ost of working	ng	16b, Kfl	ND OF BUS	SINESS/INI	DUSTRY	*
ا ڐ١	Elementary/Secondary (0-12)	College (1-4 or 5+)		usew					1	lama (+ 10		
×	17. FATHER'S NAME (First, Middle, Last)					omes							
Charles Conaway Cockey Step INFORMANT'S NAME (ROPERTY) LAD MAN INC. DEPOSITOR OF THE PROPERTY OF THE PROPERT											Surname)		
2	Reed Cockey Hayni								Baltin				1 21212
	20e. METHOD OF DISPOSITION							oud i					
	20e. METHOD OF DISPOSITION 1 Diuriel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State												VII, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559												
	23. PART I. Entar the disesses, Dr	complications that	csusad the de	sth. Dp r	opt enter	tha mo	de of dyl	ing, such	aa cardisc	Dr respi	ratory an	rest.	Approximata
	ahock, pr hasrt failure. IMMEDIATE CAUSE (Final	List only one caus	e on each line).									interval Batween Onset and Death
1 1	disease or condition resulting in death) a. CARDIO PULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF):											Onset and beating	
	DUE TO (OR AS A CONSEQUENCE OF):											3 11/10	
Z	MULTIPLE ORGAN SY (TEM FAILYRIT											7 DAYS	
CERTIFICATION	of tary, leading to immediate Due to (or as a consequence of):										- 0.		
2	Cause. Entar UNDERLYING CAUSE (Disesse or injury	*				15							30 VAYS
발	that initisted events resulting in death) LAST	DUE TO (C	OR AS A CONSEC	OUENCE OF	7):								
<u>H</u>	d.												
	PART ii. Other significant condition	ns contributing to d	eath but not r	eaulting i	n the unc	dariying	g cause g	ivan in P	Part I. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
		***							_ ''	_ TES 2	NO.		OF DEATH?
2	DID TOBACCO USE CONT	RIBUTE TO CAU	ISE OF DEA	TH YE	SΠN	10 F	1 UNC	FRTAIN	IN				1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT			2 0110	EKI/AII (
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nurs		s 5 □ Pa	eldence B	Other (Sc	noith)			
PHYSICIAN	27. MANNER OF DEATH	28e. DATE OF II	NJURY	28b. TIM	E OF	28c. INJ	URY AT	-	28d. DESCRI		JURY OC	CURED	
ВУ Р	1 Natural 5 Pending	(Month, Day	; Year)	INJ	URY M		RK? YES 2		,				
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY - At ho	me, ferm, s	treet, tecto	ry, office	•		281. LOCATIO	N (Street a	nd Number	or Rural Ro	oute Number.
	4 Homicide determined	building, et	в. (эрөспу)						City or To	wn, Stete)			
7	290. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of m	ry knowledge, de	ath occum	d at the tir	ne dete	and place	and due to	o the owner) and			
COMPLETED													end manner ee stated.
296. SIGNATURE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Frontin, Day, 1)													
										OF			
유	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (ITEM	M 27) (Type,	Print)		23	- 1)	7			1111	7)
	JOHN LEVON		6701	N.	CH	ARC	ES	ST	GA	Tim	OPE	m	1 21204
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	S SIGNATURE	, , ,						, , ,	- / 0	19	. 7/707
	NOV 1 6 1985	Valia Dave	dear Rail	-11									

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		1 - STATE REGISTRAR	STATE OF MARY			F DEATH	MENTAL HYGIEN REG. NO	E		
		1. DECEDENT'S NAME (First, Middle, Last)	HILL	ARD			2. DATE OF DEATH MONTH DO		3. TIME OF DEATH AM	
, 3 should		4. SOCIAL SECURITY NUMBER 4 251 - 54 - 2730		(In yrs. lest birthday) 59 YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) July 21, 19	10.0	HIRTHPLACE (State or Foreign Country) Uth Carolina	
	DR.	98 FACILITY NAME (If not institution, give s	WEST STATES	DS PITAL		N OR LOCATION OF DI	EATH	9c. COUNTY		
ges 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	7		Y, TOWN OR LO			7 7-7	10d. INSIDE CITY	
permit. Pages		Maryland Princ 100. STREET AND NUMBER	e George's	Cl	inton	10f. ZIP CODE		10e. CITIZEN	LIMITS? 1 YES 2 NO OF WHAT COUNTRY?	
isi	FUNERAL	9211 Stuart Lane				20735		u.s	.A.	
a a	B	1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 K NO	If yes,	DECENDENT OF HISPAI apecify Cuban, Mexics (ES 2 NO Specif		or No 14.	RACE — American Indian, Black, White, etc. Specify: Black	
. 6 .	COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)		III/e. Do NOT u	work done during se retired.)		16b. KIND OF BUS		RY	
y be retained by the hospit page 5 should be detached be notified at once.	OMP	10th 17. FATHER'S NAME (First, Middle, Last)		Handyma	n	18. MOTHER'S NA	ME (First, Middle, Maiden	lential Surnama)		
	BE	Wandy Hilliard 180. INFORMANT'S NAME (Typo/Print)	Cousin)	19h MAII INC	ADDRESS (Street	Maybelle	Fogle Route Number, City or Tow	a State 7/a Cod		
	임	Geraldene Pelzer		239 5	3rd St.	., N.EWa	shington,		20019	
		20e. METNOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem 4 Donation 5 XOther (Specify) \(\frac{1}{2}\)	State ce	b. PLACE AND DATE emetery, crematory or c	other place)			CATION — City of		
death. e funera il.		State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559								
within 24 hours at pletely filled in by cremation, or remoremt, the medical		23. ART I. Enter the diseases, of a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that cause con List only one cause on	od the death Do- each line.	pot enter the i	mode of dying, suc	actur	retory arrest,	Approximata interval Between Onset and Death	
n certificate be execunding physician and Hygiene prior to bur or other traumatic	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
that the death ned by the atte that and Mental any Injury, o	CAL CE	PART if. Other aignificant condition	s contributing to death	but not resulting	in the underly	ing cause given in	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
w requires that been signed in pt. of Health a 3 shows any	MEDI				/		1 YES 2	idao	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
De tra	SIAN:	DID TOBACCO USE CONTI		26. PLACE OF DEA			V 🔲 📗			
CLAN: Sertifications the St	PHYSICI	1 TYES, 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Ou 280. DATE OF INJURY			ome 5 Rasidence	8 Other (Specify) 28d. DESCRIBE NOW II	NJURY OCCURE	D	
DING PHYS After this death with	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28e. PLACE OF INJUR		M 1	WORK? YES 2 NO				
STOR: after after	ETED	3 Suicide 8 Could not be determined	building, atc. (Sp.	ecity)	street, factory, or	nice	28f. LOCATION (Street e City or Town, State)		ural Houte Number,	
	COMPLI		CIAN: To the best of my known of the best of axamination						use(e) end manner ee stated.	
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 IMPORTANT: If	O BE C	296. RIGHATURE AND TITLE OF CERTIFIER	52 M	D Alt	endi	298 LICENSE NUM	2453S	29d. DATE SIG	NED (Month, Def. Year)	
		NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Type		1			2022	
		LAXMI BEAN 31. DATE FILED (Month, Day, Year)	a. 770	D OLD !	BLANCI	4 AVENU	K CL	INTON) MANY/AND	

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BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

		FOR
1	_	STATE
	_	REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF	DEATH	F	EG. NO.				
1	1. DECEDENT'S NAME (First, Middle, Last)	11:	ADDIC			2. DATE OF MONTH	DEATH	Y	YEAR	3. TIME OF DE	ATH
-	TEDDY		ARRIS			AUGUS		2,19	95	18:45	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE 1 [X] M 2 [F] 5 (F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF I (Month, Di	y, Year)	995	8. BIRTI Count	HPLACE (State or ry)	Foreign
E CH	99. FACILITY NAME (If not institution, give st 6900 CONTEE RD			b. CITY, TOWN O	R LOCATION OF DE	EATH			NTY OF E	GEOR	GES
DIRECTO	RESIDENCE OF DECEDENT								10d, INSIDE CI	TY	
	A ATOME AND MUMERO			Total						1 YES 2	
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE			10g. CIT	IZEN OF	WNAT COUNTRY	?
a a	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 YES 2 NO Specify: 1. Specify:					dien,		
LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		16e. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during mo-		16b. KIN	ID OF BUS	INESS/IND	DUSTRY	-	
COMPL	AT PATHERIO MARIE (First Middle (and)										
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Midd	le, Maiden :	Sumame)			
IO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ADDRESS (Street a	nd Number or Rural i	Route Number, (City or Town	n, Stete, Zip	o Code)		
	20e. METHOD OF DISPOSITION 1	oval from State Co	Ob. PLACE AND DATE OF emetery, crematory or other		me of	DATE	20c. LO	CATION —	City or To	own, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC		ade. Dir.	22, NAME AN	d address of fa Anatomy	сјулту ,	155	(1) D	0.4		
	A cherry 1	11 her.		State	Anatomy 6-Baltin	Boara-	655	W. B	alle	more Si	reei
	23. VART I. Enter the diseases, or c shock, or heert fellure. I IMMEDIATE CAUSE (Finel disease or condition	Liet only one ceuee on	ed the death. Do no eech line.	ot enter the mo	de of dylng, suc	h as cardiac	or respin	ratory an	rest,	Approxi	
	resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF) 01-1-	TOPU						
A I ION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	if any, leading to immediate									
CERTIFICATION	CAUSE (Disease or Injury thet initiated evente resulting in death) LAST	CAUSE (Disease or Injury that initiated evente DUE TO (OR AS A CONSEQUENCE OF):									
	PART II. Other eignificent condition	e contributing to deeth	but not resulting in	the underlying	ceuee given in	Pert 1. 24	I. WAS AN	AUTOPSY	248	. WERE AUTOPSY	FINDINGS
EDICAL	PERFORMED?							AVAILABLE PRIC COMPLETION D OF DEATH?	F CAUSE		
ME	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YES	I NO TO	UNCERTAIL	NΠ				1 YES 2	NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH								
2	1 TYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Ou		OTHER: 4 - Nursing Hom	a 5 🗆 Residence	8X□ Other (S)	pecify) I	N A	GUL	LEY	
	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year,	20b. TIME INJU	RY WO	RK?	28d. DESCRI					
2	1 Natural 5 Pending 2 Accident Investigation	UNKNOW			ES 2 NO		_			SHOT	
3 Suicide 6 Could not be determined 288. PLACE OF INJURY — At home, term, street, fectory, office building, stc. (Specify)							r or Rural	or Rural Route Number,			
COMPLE	onel	CIAN: To the best of my kno								s) and manner e	n stated.
	295 SIGNATURE AND TITLE OF CERTIFIER	R & ,			29c, LICENSE NUI	MBER		29d. DAT	TE SIGNEI	D (Month, Day, Ye	er)
10 BE	30. NAME AND ADDRESS OF PERSON WH	Mull	DEATH GYPTA AT 1	Online	O.C.M				JGUS		1995
	MARYDONOR	1. KORFU	111 Pe	nn Str	eet, Ba	altimo	ore,	Maı	ryla	nd 21	201
	31. DATE FILED (Month, Day, Year) NOV 1 & 1995	Jalia Dance	Randall								

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH		AL HYGIENE REG. NO.					
	t. DECEDENT'S NAME (Figst, Middle, Lest)	rwks			2. DATI		YEAR 6000 A M				
	SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPL										
	219-01-0297 1 DEM 2 F 80 YRS. MONTHS DAYS HOURS MIN. SET 915 VIRG. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
OR	SINAI HUSPITAL BALTIMORE N/A										
DIRECTOR	10e. STATE 10b. COUNTY	A1/0	tOc. CITY, TO	WN OR LOCATION		<u>-</u>	tod. INSIDE CITY				
	10e, STREET AND NUMBER	N/A	DA	101. ZIP CODE		t0g, CITIZE	t PYES 2 NO				
FUNERAL	2578 DRUID PARK DRIVE 21215 U.S.A										
	tt. MARITAL STATUS t Never Married 2 Married	Plack White									
D BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUC	WWII	tea. DECEDENT'S USU			b. KIND OF BUSINESS/INDU	BLACK				
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +)		done during most of working		6755	1				
OMP	t7. FATHER'S NAME (First, Middle, Last) 4	Λ./	LRANE	18. MOTH	ER'S NAME (First,	Middle, Maiden Surname)					
BE C	William HA	WKS		DE	HA	FTZGER/	120				
5	ALICE N	AWKS	25 74	RUID	PATRIX	DR BALT M	797,21215				
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo	val from State 20b.	PLACE AND DATE OF DI	SPOSITION (Nerge of	11/1	TE 20c. LOCATION - CH	ty or Town, Stata				
	4 Donation 5 Other (Specify)	NSEE	LUMINUNI	22. WHIE AND ADDITES	s 977 PULLED VI	A FINERAL	Home VA				
	* Xnest 17. 71	forch	- Andrews	270 FR	12DAI	JON 8155 7	3ALT.MD, 21229				
	21 PART t Philar tha diseases, or co	implicationa that caused list only one cause on a	I the death. Do not on the line.	enter the mode of dyle	ng, auch aa ca	rdiac or reapiratory arrec	Approximata Interval Between Onset and Death				
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Cerebr	al Vas	cular A	ccicle	nt-					
z		DUE TO (OR AS A	CONSEQUENCE OF):		•						
CERTIFICATION	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING										
TIFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):								
CER		resulting in death) LAST									
CAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE ARLIA COMPT										
MEDI	t YES 2 NO COMPILE OF DEA										
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR		F DEATH YES		ERTAIN						
YSICI	EXAMINER? 1 YES 2 NO	HOSPITAL:		HER: Nursing Home 5 Rec	sidenca 6 🗆 Oti	her (Specify)					
	27. MANNER OF DEATH t Netural 5 Pending Investigation	(Month, Day, Year)	28b. TIME OF	28c, INJURY AT WORK? M t YES 2	-	ESCRIBE HOW INJURY OCCU	RED				
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, term, stree	t, tactory, office	26t. LC	OCATION (Street and Number of ty or Town, State)	r Rural Route Number,				
LET	20a CERTIFIER	CIAN: To the best of my know	ledge, death occurred a	the time, date and place,	and due to the o	euse(e) and manner es atatec	d.				
COMPLETED	anal						cause(a) and manner as stated.				
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	na - house	e stroll.	29c, LICE	NSE NUMBER		SIGNED (Month, Day, Year) Vember 15 1995				
10	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OE		i)	IVED EIT	אין עודאטד					
	31. DATE-FUED (MOND), APEX MORE)	MD 24		Belveden	Ave	Dalto,	MD				
	NUV 1 6 1995 /	Ly allumber des	res.								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	Item17 11-16-95 FilmG	729 W.H.	Per F/	H.		95	34626			
	FOR STATE OF MARYLA 1 - STATE REGISTRAR			HEALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	02.11111	OATE C		2. DATE OF DEATN		3. TIME OF DEATN			
	Helen K Hyall 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In	yrs. lest birthdey)	IF UNDER 1 YEA	IF UNDER 24 HRS.	November 15	MONTH DAY 1995 DATE OF BIRTIN 0. BIRTINPLACE (State or For				
	216-43-6887 10 M2 dF 90		MONTHS DAY	S HOURS MIN.	7-23-0	-23-05 Maryland				
ac	on Facility NAME (If not institution, give street and number) Chapel Hill Convalescent	t Hama		N OR LOCATION OF D	DEATH	9c. COUNTY OF DEATH Baltimore				
010	RESIDENCE OF DECEDENT		, TOWN OR LO			Barchiore				
DIRECTOR	Maryland Carroll		10d. INSIDE CITY LIMITS? 1 YES 2 X NO							
	10e. STREET AND NUMBER	1 0)	kesville	10t, ZIP CODE			N OF WHAT COUNTRY?			
FUNERAL	405 Hawkridge Lane			21784			S.A.			
BÝ FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	2 X NO	If yes		NIC ORIGIN? (Specify Young, Puerto Rican, etc.) illy:	ns or No— 1	Bleck, White, etc. Specify: White			
0	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	USUAL OCCUP	ATION most of working	16b, KIND OF B	JSINESS/INDU	STRY			
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	Homemak	e retired.)		1 6/0	Own Hor	Homo			
OME	17. FATNER'S NAME (First, Middle, Last)	TRAIREILE		18. MOTNER'S N	AME (First, Middle, Maide					
BEC	TOTAL DELIVERY	E. Kraft		Augus		/				
10	190. INFORMANT'S NAME (Type/Print) Edith Sue Curry (friend)	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Hawkridge Lane Sykesville, Maryland 21784								
	1 X Buriel 2 Cremetion 3 Removal from State ceme	PLACE AND DATE C	her placel				y or Town, State			
	4 Donestion 5 Other (Specify) LO:	rraine Par	22. NAM	ery November E AND ADDRESS OF F	: 17, 1995 Wo	odlawn,	Maryland Warren			
	Turrence At	9					Varyland 21228			
	23. PART i. Enter the diseases, or complications plat caused									
	shock, or heart fallure. List only one dause on each line. IMMEDIATE CAUSE (Final disease or condition Color Care 3									
	reaulting in death) a a			C 47			3413			
N	Sequentially list conditions,									
ATIC	if any, laading to immediata couse. Enter UNDERLYING									
RTIFICATION	CAUSE (Disease or Injury that Initiated events out TO (OR AS A	CONSEQUENCE OF	F):							
CER	resulting in death) LAST									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PREFORMED? AMAILABLE PRIOR TO									
MEDICAL		1 U YES 2 AND COMPLETION OF CAUSE OF DEATN?								
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	F DEATH YE	S NO	UNCERTA	IN 🗹		1 TYES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEAT	OTHER:	one)						
IXSI	1 ☐ YES 2 ☑ NO ☐ 1 ☐ Inpatient 2 ☐ ER/Outpa 27. MANNER/ OF DEATN ☐ 28a. DATE OF INJURY	atient 3 DOA	4 Nursing	Nome 5 Residence	6 Other (Specify)	IN ILIBA OCCI	DED			
6 [1 Natural 5 Pending (Month, Day, Year)		URY	WORK?	Zau. Deschibe Non	INJUNT CCC	neb			
TED BY	2 Accident investigation 3 Suicide 6 Could not be detarmined 4 Nomicide detarmined	— At home, term, :	street, factory,	office	261. LOCATION (Stree City or Town, State	t and Number o	Rural Route Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge one) 2 MEDICAL EXAMINER: On the basis of axamination									
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	ar n		29c. LICENSE N		11.	SIGNEO (Month, Day, Year)			
10 8	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA		. Print)	035	883	1	1/15/95			

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) MO Reinferstown

SAN SAN STUDE

			t. Pages
	BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages
1		in 24 h	shy fille
	DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	STOR: After this certificate has been signed by the attending physician and completely
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: It Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRÀR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. 0	DECEDENT'S NAME (First Middle Last)		2 DATE OF DEATH

1. DECEDENT'S NAME (First, Midd	210	Margar	et E. I	Holma	5/	W e	5		2. DATE O		DAY D7	YEAR	3. TIME OF DEATH 8:40 P														
4. SOCIAL SECURITY NUMBER		SEX	6. AGE (In yrs. It	ast birthday)		R 1 YEAR	IF UNDER		7. DATE C	F BIRTH		8. BIRTHI	PLACE (State or Foreign														
215-18-5021	1	□ M 2 XF	77	YRS.	MONTHS	DAYS	HOURE	MIN.	JUN .	Day, Year,		M A D	YLAND														
9a. FACILITY NAME (If not institution	on, give street	end number)			9b. CIT	Y. TOWN C	OR LOCATIO	ON OF DE		1,		NTY OF DE															
BON SECOURS HOSPITAL							10RE					N/A															
10a. STATE 10b. COUNTY				10c. CIT	Y. TOWN	OR LOCAT	TION						10d. INSIDE CITY														
MARYLAND BALTIMORE					AMON								LIMITS?														
	10e. STREET AND NUMBER				ATUI	VSVII	LLE LZIP CODE				10- CIT	AZENI OE W															
	715 MAIDEN CHOICE LANE					101		1228				U.S.A.															
11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 VE			YES 2 X	NO NO	13.	If yes, sp	ENDENT O ecity Cuber 2 X NO	n, Mexica	in, Puerto R	(Specify Ican, atc.)	Yea or No-	14. RACE Black Specifi	- American Indien, White, etc.														
15. DECEDEN				ECEDENT'S					16b.	KIND OF	BUSINESS/IN	DUSTRY															
(Specify only high Elementary/Secondary (0-12)	1	college (1-4 or 5	- 4	(Give kind of lie. Do NOT u	work done se retired.)	during mo	est of workin	g																			
12		onege (1-v or o	·	SHIPP	TNG	CLER	K			FOO	DD STO	RE															
17. FATHER'S NAME (First, Middle,	Last)					~~.u.u.k		IER'S NA	ME (First A4		ien Surname)																
ROBERT C.		NDERLY					177																				
19a. INFORMANT'S NAME (Type/Pr		MUEKTI		104 PRACE		20.75		ENNI		IAVE																	
The state of the s		1.0									Town, State, Zi																
THOMAS V. McGU	JINNES	S		5762	IRIS	SH CR	EEK 1	DR.	NORTH				m 21662														
20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3	☐ Removal	from State	20b. PLACI	EAND DATE	OF DISPO	SITION (Na	ame of		DATE	20c.	LOCATION -	City or Tov	vn, State														
4 Donation 5 D Other (Spec	offy)		LOUD	ON PA	RK C	EMET	ERY		11-1	1 BA	LTIMO	RE. M	IARYLAND														
21. SIGNATURE OF FUNERAL SEF	RVICE LICENS	SEE /			22	. NAME AL	ND ADDRES	SS OF FA	CILITY																		
Pally	0 ~	Harle	,		7	36 F	ING A	ASHT	ON FU	JNERA	L HOM	E, IN	D 21228														
23. PART I. Enter the disease shock, or heert IMMEDIATE CAUSE (Final disease or condition resulting in death)	fellure. List	t only one cau	se on each lin	ne.	not ente	r the mo	da of dyl	ng, suc	h aa cerdi	lec or re	epiratory si	rest,	Approximate Interval Betwee														
ahock, or heert immediate cause. Entar UNDERLYING CAUSE (Final disease or condition resulting in death) Sequentially list conditione, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events	fellure. List	A C DUE TO AUE TO	t caused the caused in the cau	EOUENCE C	not ente	r the mo	da of dyl	ng, suc	h aa cerdi	lec or re	epiratory si	rest,	Approximate Interval Betwee														
ahock, or heert in the property of the propert	fellure. List	A C DUE TO AUE TO	OR AS A CONSI	EOUENCE C	not ente	r the mo	da of dyl	ng, suc	h aa cerdi	lec or re	epiratory si	rest,	Approximate Interval Betwee														
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-729 11/20/95 t.t

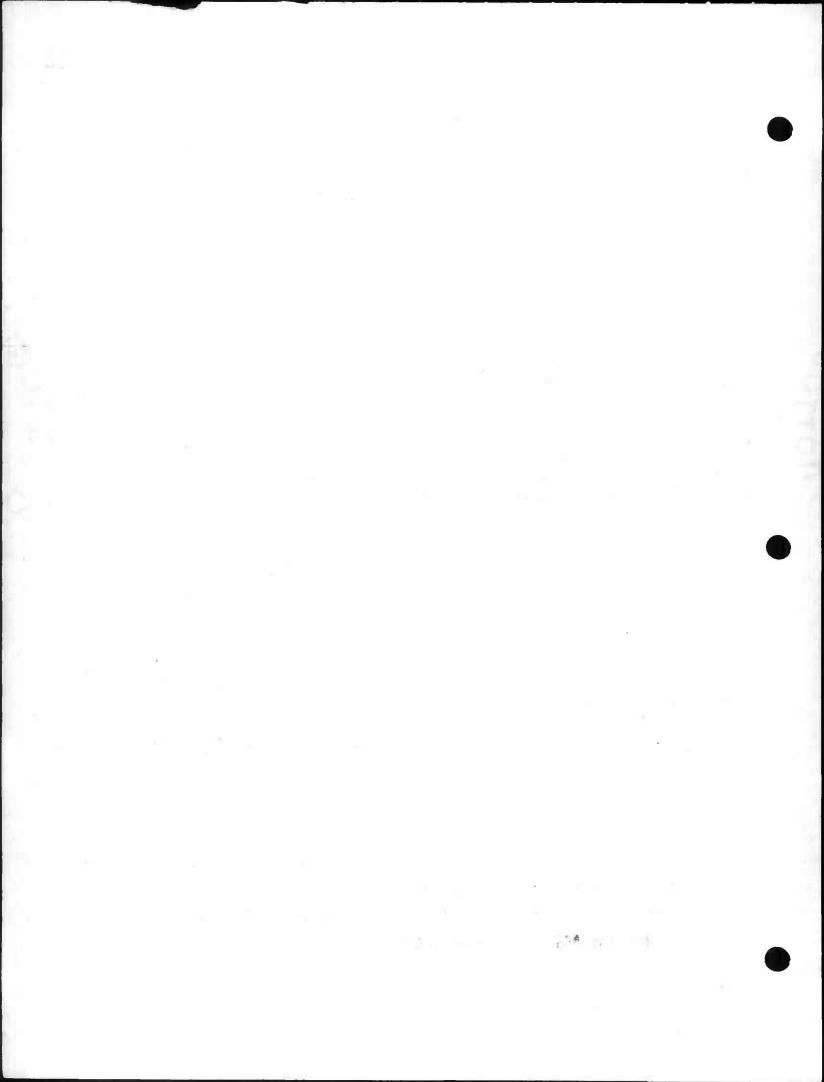
95-276 95 346**28**

	1 - STATE REGISTRAR	STATE OF MA			TMENT ICATE					HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH	w	YEAR	3. TIME OF DEA	тн
	CYNTHIA			JOY	CE_			NO	VEMBE				1:12	Рм
			AGE (In yrs. last 29	birthday)	IF UNDER	I YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, D			8. BIRTH Countr	IPLACE (State or F	oreign
		□ M 2 🖔 F	29	YRS.	BOWNE	on io	Houns	Janua.	Aug.	11, 1	966			
~	9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								EATH					
DIRECTOR	708 WEST LAYFAYE		BALJ	CMI	RE									
EC	10a, STATE 10b, COUNTY				Y, TOWN C		ION						10d. INSIDE CIT	Y
10	Maryland			Ва	ltim	ore							LIMITS? X YES 2	NO
AL	10e. STREET AND NUMBER						ZIP CODI				10g. CITI	ZEN OF	WHAT COUNTRY?	
FUNERAL	408 N. Kenwood Aver	rue					1224					u	I.S.A.	
E	11. MARITAL STATUS 12 1 Never Married 2 Married	. WAS DECEDENT E FORCES? 1							NIC ORIGIN? (or No-	14. RACI Black	E — American Ind k, White, stc.,	lan,
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES				2 X NO					Spec	k, white, stc. Hy: Black	
	15. DECEDENT'S EDUCATI		16a. DEC	CEDENT'S	USUAL O	CCUPATIO	ON		18b. Ki	ND OF BUS	SINESS/IND	USTRY		
ET	(Specify only highest grade con Elementary/Secondary (0-12)	college (1-4 or 5+)	(Gh	ve kind of Do NOT u	work done se retired.)	during mo	st of workin	ng						
MP														
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First, Mid	dle, Maiden	Sumame)			
BE														_
2	19a. INFORMANT'S NAME (Type/Print)		196	MAILING	ADDRES	S (Street a	nd Number	or Rural i	Route Number,	City or Tow	n, State, Zip	Code)		
	20e. METHOD OF DISPOSITION		20b. PLACE A	ND DATE	OE DISPOS	NOTION /No	ame of		DATE	200 10	CATION —	City or Tr	nwn State	
	1 Burial 2 Cremation 3 Removal 4 Donation 5 Donation 5 Donation		cemetery, crer				mo or		DATE	200.00	ON 1011	only of it	own, otals	
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENS		wade. I	ir.	22.	NAME AN	ID ADDRE	SS OF FA	CILITY	155	(u) D	- 0+:	more St	400t
	Manay 1111	200-	uli	10-	St	ate.	Anai	.omy	Boara	-655 Marul	W. D	210	.more sc 201-1559	reei
	23. PART I. Enter the diseases, or com	pilestions that c	sused the de	ath. Do									Approxim	
	ehock, or heert fellure. List only one cause on each line.										Between			
	disease or condition AICOHOL AND NADCOTIC INTOXICATION													
	DUE TO (OR AS A CONSEQUENCE OF):													
Z	6 b.													
CERTIFICATION	Sequentially list conditione, If any, leading to Immediate cause, Enter UNDERLYING													
FIC	CAUSE (Disease or Injury C	DUE TO (O	R AS A CONSEC	UENCE O	FI:									
FE	thet initieted evente resulting in deeth) LAST				. ,.								Ì	
	σ												1	
CAL	PART II. Other eignificent conditione of	ontributing to de	eth but not re	eeuiting	in the u	nderiyin	g cause	given In		4s. WAS AN	RMED?	240	AVAILABLE PRIOR	TO TO
									— l	YES 2	□ NO		OF DEATH?	CAUSE
M	DID TORACCO LISE CONTRIB	LITE TO CALL	CE OF DEA	TII V		NO E	7 11512	COTAL		1			1 YES 2	NO
AN	DID TOBACCO USE CONTRIB	OTE TO CAU			TH (Check] UNC	CERTAI	иП	_				
PHYSICIAN: MEDI	EXAMINER?	OSPITAL:			OTHE	R:		[4]	XXOther (Daniel I	VACA	NТ	DWELLI	NG
H	27. MANNER DF DEATH	28a. DATE OF IN	JURY	POUN		28c. INJ	URY AT	BROSTICE	28d. DESCI	-,,,			DWEDET	140
ВУ Р	1 Nstural 5 Pending 2 Accident investigation	FOUND: 11		1:03		1 🔲	YES 2X	X NO	UNKNOW	IN				
	3 Suicide 8 X Could not be	28a. PLACE OF I	NJURY — At ho	ma, farm,	atreet, lac	tory, offic	a		281, LOCAT	ION (Street	and Number	or Rural	Route Number, AVETTE AVI	EMILE
COMPLETED	3 Suicide 4 Homicide 8 XX Could not be determined 288. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) FOUND: ABANDONED BUILDING 288. LOCATION (Street and Number or Rural Route Numbe								LHUL					
IPLI	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	N: To the best of m	y knowledge, de	ath occur	red at the	time, date	and place	, and due	to the cause	(a) and ma	nner aa ata	ted.		
SON	2 MEDICAL EXAMINER:	On the basis of exar	minstion and/or i	rivestigati	on, in my	opinion, d	fasth occu	red at the	time, data ar	nd place, er	nd due to th	na cause(a) and manner as	atated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	11-2	1				29c. LIC	ENSE NU	MBER		29d. DAT	E SIGNES	D (Month, Day, Year)
TO B	Mestone	M. M.	ng -				0.	C.M	i.E.	NO	VEMB	ER	4, 199	5
_	30. NAME AND ADDRESS OF PERSON WHO C											_		
	HEO DOREM.	10	111	Per	nn S	tre	et,	Bal	timo	re,	Mary	lan	d 2120	1

32 REGISTRAR'S GIGNATURE

NOV 1 6 1985

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicians.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1 - STATE REGISTRAR	STATE OF MA		MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.			
1. DECEDENT'S NAME (First, I		JENKINS		2. DATE OF DEATH NOVEMBER		3, TIME OF DEATH 4:00 p M	
4. SOCIAL SECURITY NUMBER 217-12-0127	1 □ M 2 □X 🕏	76 yrs.	F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN.	7. DATE OF BIRTH FEB. 297 1941 9			
90. FACILITY NAME (I) POLING MEREDIA BESIDENCE OF DECI)ME	perring park	(Way)	9c. COUNTY OF BAL	TIMORE CO.	
)	10b. COUNTY n/a	10c. CITY, 1	TOWN OR LOCATION BALTIMORE		10d. INSID X LIMIT 1 YES		
10a. STREET AND NUMBER	ENWORTH AVENU	JE	101. ZIP CODE 21234	1	10g. CITIZEN OF UNITED	STATES	
Widowed 4 Divon	THE MED OWN THE	YES 2 XXVO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 XXO Specif	an, Puarto Rican, atc.)	Bia	CE — American Indian, ick, Whita, atc. pctty:BLACK	
15. DECE (Specify only) Elamentary/Secondary (0- 12 th 17. FATHER'S NAME (First, Mich.	DENT'S EDUCATION highest grade completed) 2) College (1-4 or 5 +)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during most of working etired.)	16b. KIND OF BUS		ades	
17. FATHER'S NAME (First, Mic	dle, Lest) ILLIAMS		18. MOTHER'S NA BLA	NCHE WIL	Sumame) LIAMS		
190. INFORMANT'S NAME (Ty) IRENE	CROSBY	19b. MAILING AI 4138	ODRESS Street and Number of August THE ALAMET	JA, NUBALTIMO	RE, ZIO Gode)	21218	
20a. METHOD OF DISPOSITION X Burlal 2 Cremation 4 Donation 5 Other (21. SIGNATURE OF FUNERAL	3 Ramoval from Stata Specify)	20b. PLACE AND DATE OF COMPANY COMMENTS OF COMPANY COMMENTS OF COMPANY		11-18 R	ANDALLS	TOWN, Stata TOWN, MD	
- Jana	she shad			CH FH1101		RTH AVENUE	
shock, or he IMMEDIATE CAUSE (Fine disease or condition resulting in deeth) Sequentielly list condition if sny, leeding to immed ceuse. Enter UNDERLYIN CAUSE (Disease or injur thet initieted evente resulting in deeth) LAST	a. DUE TO (O	LON CA	AJECINOMA VE HEAIR	WITH 1	NETAS	Approximate interval Between Onset and Deeth	
				PERFOR	MED?	Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE	
	E CONTRIBUTE TO CAU	SE OF DEATH YES	□ NO □ UNCERTAL	1 YES 2	Х, Хио	OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL HOSPITAL:	26. PLACE OF DEATH					
27. MANNER OF DEATH 1 Matural 5 F	28e. DATE OF IN (Month, Day,	JURY 286, TIME (OF 2Sc, INJURY AT		8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED		
3 Suicida 6 0	2 Accident investigation 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State						
ana)	FYING PHYSICIAN: To the best of m					e(a) and manner as atated.	
29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20 (Tops Prior))						ED (Month, Day, Year)	
100							
30. NAME AND ADDRESS OF SHALLS A	PERSON WHO COMPLETED CAUSE HASHM	851 N.	EUTAW ST	Suite:	301	Balty more	

PHYSICIAN:

BY

COMPLETED

BE

2

1 TYES ENO

27. MANNER DF DEATH

Natural Accident

3 Suicide

4 Homicide

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DIVISION	

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.		arked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
4 hours after (illed in by the	n, or removal.	e medicai e
uted within 24	completely fi	rial, cremation	c event, th
cate be exect	physician and	e prior to bu	er traumati
death certif	e attending	Mental Hygien	lury, or oth
quires that the	in signed by th	with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nows any in
N: The law re	ficate has been	State Dept. of	item 23 sl
VG PHYSICIA	ter this certif	ath with the	marked, or
OR ATTENDI	DIRECTOR: After	nours after death	tem 28 is
TO THE HOSPITAL OR ATTENDING P	TO THE FUNERAL I	be filed within 72 hours after	IMPORTANT: If item 28 is mark

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 95 ARTHUR L. **JACKSON** 3:15 A November 12 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
7/14/1925 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN. 70 219-14-0139 1 M 2 - F VRS Sparks, MD 9a. FACILITY NAME (If not institution, give street and number)
921 Wilmott Court 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR N/A Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY MARYLAND N/A BALTIMORE 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 921 WILMOT COURT 21202 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 2 NO IF YES, GIVE WAR OR DATES 11/22/43-12/18/45 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: ВУ 3 Widowed 4 Divorced **Black** COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Paint Company Laborer 12th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Thomas Jackson Alice Scott BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John Paul Jackson 1501 Eutaw Place Baltimore, Maryland 21217 20a. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of 11/17 DATE company or other place) 20c. LOCATION — City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. Donation 5 - Other (Specify) _ Owings Mills, MD 21 SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE complications that coded the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximata Interval Batween shock, or heart fallur List only one cause Onset and Death **IMMEDIATE CAUSE (Final** disease or condition erebrovascular disease reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST MEDICAL

PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 1 TES 2 NO.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?**

26e. PLACE OF INJURY — At home, tarm, street, factory, offica building, atc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. DATE OF INJURY (Month, Day, Year) 5 Pending Investigation

4 ☐ Nursing Home 5 Realdence 6 ☐ Other (Specify) 28c. INJURY AT WORK? 1 YES 2 NO

26d. DESCRIBE HOW INJURY OCCURED

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER

Chack only

CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and pieca, and due to the cause(a) and menner as stated.

(Check only one)

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

		7	Bn	45	1	my	W	N	17)
0.	NAME	AND !	DORESS	OF PERSON	WHO	COMPLETED	CAUSE OF	DEATH	(ITEM 2	7) (7/

29d. DATE SIGNED (Month, Day, Year) 14

2323 Olleans

31. DATE FILED (Month, Day

29b. SIGNATURE AND TITLE OF CERTIFIER

6 Could not be

3-1-2

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARYL	ND / DEPARTI			MENTAL HYGIEN			
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			IME OF DEATH
FLORENCE Cath	nerine Bruce	9	JENSO	V	NOVEMBER	e 9,19	9 2	:20 P.M
4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)			E (State or Foreign
218-26-3601 9e. FACILITY NAME (If not institution, give	1 M 2 X F	6 / YRS.		R LOCATION OF DE	July 8, 19		Mary	land
ST.AGNES HOSP	ITAL		BALTI	MORE CI	TY		n/a	
10e. STATE 10b. COUN	TY	10c. CITY,	TOWN OR LOCATI	ON			10d.	INSIDE CITY
Maryland 100. STREET AND NUMBER	Baltimore		Catons	ville ZIP CODE		10g. CITIZEI	1 ()	YES 2 NO
517 Winters Lane			-	21228			USA	
11. MARITAL STATUS	12. WAS DECEDENT EVER IN			NDENT OF HISPAN	IIC ORIGIN? (Specify Ye	8 or No— 14		merican Indien,
1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			2 NO Specify	n, Puerto Ricen, etc.)		Specify:	ne, etc.
15. DECEDENT'S ED	I I							Black
(Specify only highest grad	le completed)	(Give kind of wor life, Do NDT use if	k done during mos		16b. KIND OF BU	SINESS/INDUS	STRY	
Elementery/Secondary (0-12) 12th Grade	College (1-4 or 5+)		k Binde	_	II S. GO	wt Pri	intin	Office
17. FATHER'S NAME (First, Middle, Last)		10001	Dinaci	•	ME (First, Middle, Maiden		LIIOLII	OILICE
William Gilbert	Bruce				e Brown	,		
19s. INFORMANT'S NAME (Type/Print)	DI GCC	19b. MAILING A	DDRESS (Street ar		Route Number, City or Tov	vn, State, Zip Co	ode)	
George W. Jenson	, Sr.	517 Wir	nters La	ane C	atonsville	, Mary	yland	21228
20a. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Rec	20b	PLACE AND DATE OF	DISPOSITION (Na			CATION — CIT		
4 Donation 5 Other (Specify)	MI MI	etery, crematory or othe Veteran (Cemetery	/Garrisc	n 15 owi	nas M	ills,	Maryland
21. SIGNATURE OF THERAL SERVICE	CENSER	1	22. NAME AN	D ADDRESS OF FA	OUTY Nutter	Funera	al Hor	mes, Inc.
Frank	K- / Em.	/-	2501 (Swynns F	alls Parkv	7ay 1216		
23. PART I. Enter the disease, or shock, or heart fellure IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	. List only one ceuse on e	ach line.	A .	Pise		matory arree		Approximate Interval Between Onset and Death
Sequentielly list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in deeth) LAST	£	SEQUENCE OF):		Dise	asl			
PART II. Other significent condition	ona contributing to death b	ut not resulting in	the underlying	ceuee given in		AUTOPSY RMED?		E AUTOPSY FINDINGS
					1 TYES	2 NO		PLETION OF CAUSE DEATH?
					-x/ '	,	1 🗆	YES 2 NO
DID TOBACCO USE CON				UNCERTAI	N DA			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)		•			
ZYES 2 NO 27. MANNER OF DEATH	1 Inputient 21 TR/Outp				8 Other (Specify)			
1/ Netural 5 Pending	(Month, Day, Year)	28b. TIME INJUI	RY WO	RK?	28d. DESCRIBE HOW	INJURY OCCU	RED	
Accident Investigation	28s. PLACE OF INJURY	- At home form et-		ES 2 NO	28f. LOCATION (Street	and Number or	Gumi Gauta	Monther
3 Suicide 8 Could not be determined	building, atc. (Spec	effy)	set, tactory, billet		City or Town, Stute)	ribrar ricote	reumber,
29e. CERTIFIER								
CERTIFYING PHY	SICIAN: To the best of my know							I menner es stated.
29b, SIGNATURE AND TITLE OF CERTIFI	en/ /	^		29c. LICENSE NUI	MBER	29d. DATE S	SIGNED (Mor	nth, Day, Year)
3 NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF OF	ATH OTEM 27 / Kerry C	Print)	O.C.M	.E.	NOVEM	IBER	10,1995
JUARON CO	SKE MO			eet, Ba	ltimore,	Mary	land	21201
31. 910 V 7 10 6.1995	ale Whitehar Con	Est.						

44 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 :

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

funeral director, the filled in by completely and physician HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be the atten been signed by the Dept. C certificate h this ca After I L DIRECTOR: A hours after d FUNERAL DIRECT within 72 hours a TANT: If Item 2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH ELSE JAFFE NOVEMBER 13,1995 8:50pm 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
JUNE 24, 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS GERMANY 1 M 2 F 96 216-18-9504 9a, FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MERIDIAN BRIGHTWOOD NURSING HOME BROOKLANDVILLE BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND N/A BALTIMORE FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21215 3806 FORDS LANE, APT. 103 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Married Specify: BY 3 🔀 Widowed 4 🗋 Divorced WHITE ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) E Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MICHAEL notified at STERNBERG BERTHA MOSES 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. ELLEN 6602 BAYTHORNE RD. BALTIMORE, MD 21209 SIEGEL 20a. METHOD OF DISPOSITION
1 Qurial 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) DATE 20c. LOCATION - City or Town, State 20b. PLACEAND DATE OF DISPOSITION (Name of CHEVRA AHAVAS CHESED 11-14-1995- RANDALLSTOWN, 21. SIGNATURE OF MINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximata ahock, or haart fallure. List only one cause on each lins. Interval Batween Onset and Daeth IMMEDIATE CAUSE (Final disease or condition 4 Months Esophageal Co Carrenoma reaulting in death) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avanta reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 OF DEATH? Ão 1 TYES 2 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL EXAMINER 2

1 YES 2 NO

27, MANNER OF DEATH THER:
4 Mursing Home 5 - Residence 8 - Other (Specify) HOSPITAL: 1 | Inpetient 2 | ER/Outpetient 3 | DOA the 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? marked, 1 Natural 1 YES 2 NO В Investigation 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, Cliv or Town, State) 8 Could not be datarmined 60 COMPLETED 4 Homicide 28 29a. CERTIFIER (Check only one)

2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occured at the time, data and piece, end due to the cause(s) and manner as stated, IMPORTANT: 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Morth, Day, Year) 29c. LICENSE NUMBER BE enery fell 033211 11/14/95 (0) 9

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THE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

York Road

32. REGISTRAR'S SIGNATURE

Suite 508

31. DATE FILED (Month, Day, Year)

NUV 1 6 1995

CHRISTINE LAFFERMAN

DR. CHRISTINE

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TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	hin 72 hours after death with the State Dept. of Health and Mental Hygien	PORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL	TO THE FUNERAL (be filed within 72 h	IMPORTANT: If I

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	1 - STATE REGISTRAR	TE OF MARYLAN	D / DEPARTA			MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)	JACKSO				2. DATE MONT	OF DEATH	i q	EAR	ME OF DEATH
	220 UI 24II	8. AGE (In y	rs. last birthday) # MO	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	SEP	OF BIRTH th, Day, Year)	1905	Country)	E (State or Foreign
TOR	9a. FACILITY NAME (If not institution, give street and NORTHWEST HOSPIT. RESIDENCE OF DECEMENT				LLSTOWN			9c. COUNTY BAL	TIMO	
DIRECTOR	MARYLAND 106. COUNTY N/A			LTIMO						INSIDE CITY LIMITS? YES 2 NO
FUNERAL	1217 N. BENTALOU				21216			U.S.	OF.	Α.
B⊀	1 Never Married 2 Married FO	S DECEDENT EVER IN U. RCES? 1 YES 2 ES, GIVE WAR OR DATE	NO	If yea, so	CENDENT OF HISPAI ecity Cuban, Mexica 2 NO Specif	n. Puerto	N? (Specify Yes Rican, etc.)	or No— 14	Black, Wh	merican Indien, ita, atc. LACK
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	d) e (1-4 or 5 +)	Give kind of work life. Do NOT use re	done during me etired.)	ost of working	161	b. KIND OF BUS	RSING	TRY	
ш	17. FATHER'S NAME (First, Middle, Last) DANIEL DUNNOCK		111111 011	11010	18. MOTHER'S NA				-	
TO B	19a. INFORMANT'S NAME (Type/Print) MR. GEORGE R. JA		19b. MAILING AD		NTALOU		BALT	TO.,M	D. 2	
	20a METHOD OF DISPOSITION 130 Burlel 2 Cremation 3 Removal from 4 Donetion 5 Other (Specify)	BAI	TIMORE	NATI	eme of 11/20 ONAL CE	Μ.		CATION — CH LTIMO		ARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE,	EWIS T. O	GWYNN	LEWI	ND ADDRESS OF FA S T. GW PARK H	YNN	FUNE			21215
	23. PART I. Enter the diseases, or compile shock, or heert failure. Liet on IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	etions that coused they one cause on each	MYO		DIAL					Approximeta Interval Between Onset and Death
ERTIFICATION	Sequentielly liet conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO								
PHYSICIAN: MEDICAL C	PART II. Other significent conditions control		not reaulting in t	the underlyin	g cause given in	Part I.	24s. WAS AN PERFOR	MED?	CON DF I	RE AUTOPSY FINDINGS ILABLE PRIOR TO APLETION OF CAUSE DEATH?
AN: M	DID TOBACCO USE CONTRIBUT			□ NO C	7 0110211111	N 🗆			'	1 1ES 2 NO
SICI		PITAL: petient 2 - ER/Outpetie		THER:	ne 5 🗆 Residence	8 🗆 Oth	er (Specify)			
	1 Natural 5 Pending	(Month, Day, Year)	265. TIME C	Y W	JURY AT ORK?	28d. DE	EŞCRIBE HOW I	NJURY OCCU	RED	
Accident Investigation 3 Suicide 8 Could not be detarmined 4 Homicide 4 Homicide 1 Homicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. LOCATION (Street and No. City or Town, State)							and Number or	Number or Rural Route Number,		
COMPLET	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To MEDICAL EXAMINER: On the									I manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMP				29c. LICENSE NU	MBER	0	29d. DATE 5	SIGNED (Mor	14 95 171122
	31. DATE FILED (Month, Day 1981) NOV 1 2 1005	TA NO	JRE JRE	EST J	TOSPITA	11	CENTI	ERP	BAU	DALLSTON

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	1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			NTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	MONROE LIN	100101			DATE OF DEATH		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	1		UNDER 1 YEAR	IF UNDER 24 HRS. 7.	DATE OF BIRTH		FITHPLACE (State or Foreign		
pin	233-16-7770	1 M 2 □ F 85	YRS. MON	ITHS DAYS H	HOURS MIN. 9	718706	٧Ĵ	RGINIA		
2, 3 should	9a. FACILITY NAME (If not institution, give NORTH ARUNA) RESIDENCE OF DECEDENT	el Hospital	9b.		LICATION OF DEATH		HAME	frundel		
permit. Pages 1, 2, 3 s (AL DIRECTOR	10a. STATE 10b. COUN	ARUNDEL		BURNIF	N			10d. INSIDE CITY LIMITS? 1 YES 2X X NO		
Permit	10e. STREET AND NUMBER		I GLEN	10f. Z	061		U.S.	OF WHAT COUNTRY?		
burial-transit	313 HOSPITAL DRIV	12. WAS DECEDENT EVER IN U.		13. WAS DECEN	IDENT OF NISPANIC	ORIGIN? (Specify Yes	or No 14. F	RACE - American Indian,		
By the by	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 V YES : IF YES, GIVE WAR OR DATE 194	2		Ify Cuban, Maxican, P NO Specify:	uarto Rican, atc.)		Specify: BLACK		
Se 3S	15. DECEDENT'S ED (Specify only highest grad	UCATION 16	Ba. DECEDENT'S USU (Give kind of work			16b. KIND OF BUS	INESS/INDUSTR	TY		
hed for us	Elementary/Secondary (0-12)	College (1-4 or 5+)	ite. Do NOT use ret CHAUI	tired.)		UNK	NWON			
uld be detached for ed at once. BE COMPLE	17. FATNER'S NAME (First, Middle, Last) ELIZA LINCOLN				18. MOTHER'S NAME NORA VIRG					
5 sho	19a. INFORMANT'S NAME (Type/Print) GWENDOLYN WILLIA	MS			Number or Rural Rout ANE APT.F					
must be	20a. METHOD OF DISPOSITION 1 XI Burlai 2 Cremation 3 Ra 4 Donaiton 5 Other (Specify)	moval from Stata 20b.PL	RISON FOR	ISPOSITION (Name	e of	DATE 20c. LOC	CATION — City of			
by the funeral director, moval.	21. SIGNATURE OF FUNERAL SERVICE L		KT20M-FOF	22. NAME AND	ADDRESS OF FACILI	TY				
i exa	ESTEP BROTHERS FUNERAL HOME PA 1300 EUTAW PLACE BALTIMORE, MAR									
filled in by the fon, or removal the medical	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Betwook, or haert fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence op): CONGESTIVE HEART FAILURE									
cremati vent, t										
traumatic e	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): METASTATIC PROSTATE CANCER									
H is phy	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO		MOS	AIC					
- U		d								
any in	PART ii. Other significant condition	one contributing to death but	not reaulting in the	he undarlying	cauae givan in Pa	24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
sho L: M	DID TOBACCO USE CON				UNCERTAIN			1 TYES 2 PYNO		
State Item	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inputient 2 ER/Output	PLACE OF DEATN (Content 3 DOA 4 DOA	THER:	5 Raeldence 6	Other (Specify)				
= 기준	27. MANNER OF DEATN 1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WOR	RY AT 20 K? ES 2 NO	Bd. DESCRIBE HOW II	NJURY OCCURE	D		
Mer de Is	2 Accident Investigation 3 Suicide 8 Could not b 4 Nomicide detarmined	28a. PLACE OF INJURY -	At home, farm, stree	nt, lactory, offica	20	BI. LOCATION (Street a City or Town, State)	nd Number or R	ural Route Number,		
AL DIRECTOR NO. 12 HOURS	(Uneck only	SICIAN: To the best of my knowled						use(a) and manner as stated.		
PORT filed v	29b. SIGNATURE AND TITLE OF CERTIF	ler fair	MD,		29c. LICENSE NUMBE	762	29d. DATE SIG	SNED (Month, Day, Year) CEMBER 8,199		
10 ₹ 8 B	30. NAME AND ADDRESS OF PERSON V		H (ITEM 27) (Type, Pri	CIAN.	NORTH	ARUNDE	EL HO	SPITAL		

M·SHIRAZI, 31. DATE FILED (Month, Day, Year) NOV1 61995

32. REGISTRAR'S SIGNATURE

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificant be associated within 24 hours after theseth. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physicals and comparing fleet in by the human director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Deat of Health and Merital Horizon programment or manner.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical axaminer must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYG			
	1. OECEOENT'S NAME (First, Middle, Last)					2. DATE OF OEA	TH	3. TIME OF OEATH	
	Ava Elizabeth	Marshall				November	DAY 15 19	195 12:25 P	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (1	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	н	8. BIRTHPLACE (State or Foreign	
	234-38-8259	1 M 2 2 F	9 YRS.	MONTHS DAYS	HOURS MIN.	MARCH 3		West Viewal	
	Se. FACILITY NAME (If not institution, give stre	///////////////////////////////////////		9b. CITY, TOWN	OR LOCATION OF			TY OF DEATH	
OR	FALLSTON GE,	N /tospita	C	1	ALLSTO.	N	1-	TARFORD	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			V 70401 00 100					
E	U	400-00	100. 01	Y, TOWN OR LOC				10d. INSIDE CITY LIMITS?	
4	10a. STREET AND NUMBER	THEFORV			ALLSTO	N		1 TES 2 TO NO	
FUNERAL	366 A CANTER	chier Rd	,	- 1	ELEKA TIRE	21014 10g. CITIZEN OF WHAT COUN			
N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS OF	21014	NIC ORIGIN? (Speci	fy Van or No	14. RACE — American Indian,	
	1 Never Married 2 Married	FORCES? 1 YES		If yes, s	pecify Cuban, Maxic S 2 NO Speci	an, Puerto Rican, et	c.)	Black, White, etc.	
ВУ	3 Widowed 4 Divorced			'''	o i gallo apaci	ny.		specify: White	
COMPLETED	15. DECEOENT'S EOUCA (Specify only highest grade of	ATION ompleted)	(Give kind of	USUAL OCCUPAT	ION lost of working	16b. KINO O	F BUSINESS/INOU	ISTRY	
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)			0,	Home	
MP	8th GRADE	N.A.	/"	tomem,	AKER		OWN	TOME	
8	17. FATHER'S NAME (First, Middle, Last)		1-1		16. MOTHER'S N.	AME (First, Middle, M	aiden Surname)		
BE		ussell 1	Jelson		SAL	LLIE	WARR	VER	
6	19a. INFORMANT'S NAME (Type/Print)		-		/	Route Number, City of	r Town, State, Zip C	1	
.	20a. METHOD OF DISPOSITION	TELLE PENNET	# 300	11 CA	Nterb		. DEIA	1R, MA 2101	
	1 X Buriel 2 Cremation 3 Remov		PLACE ANO OATE		ieme ol Lemeter	DATE 20		Ity or Town, State	
1	21. SIGNATURE OF FONERAL SERVICE LICE	NSEE 2	ORTH FOI		NO ADDRESS OF F		liverton	. W. VIRGINIA	
	>//heal	120		Jose	ph N. Z	PUNINO	JR. F	- UNCRAL HOM	
_	- Crany	Janne	no	263	S. CON	Kling 5	St. BAI	160 MQ 21224	
	23. PART I. Enter the diseases, of co shock, or heart failure. L	in plications that coused at only One couse on ec	the deeth. Do i ch line.	not enter the m	ode of dying, suc	ch as cerdiec or	respiratory srre	st, Approximete Interval Between	
	IMMEDIATE CAUSE (Final disease or condition	ACUTE		- n + 1 c	111 10	1000		Onset and Deat	
- 1	resulting in death)				LAR	11/22 CE	22	10 DAYS	
	OUE TO (OR AS A CONSEQUENCE OF):								
8	Sequentially list conditions, Oue to (or as a consequence of): DIABETES NON-INSULIN DEPENDENT Oue to (or as a consequence of):								
ξI	if any, lesding to immediate cause. Enter UNDERLYING	00E 10 (011 A3 A	CONSEQUENCE O	r).					
윤	CAUSE (Disease or injury that initiated events	OUE TO (OR AS A	CONSEQUENCE O	F):					
CERTIFICATION	resulting in deeth) LAST							ļ	
	DADT II. Other simulticent conditions								
SAL SAL	PART ii. Other significent conditione CONGESTIVE		FAILU!		ig ceuse given in		S AN AUTOPSY RFORMEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă				16		1 🗆 YI	S 2 10 NO	COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: MEDIC	CHRONIC R							1 TES 2 NO	
AN	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL					N 🗆			
2	EXAMINER?	HOSPITAL:	6. PLACE OF OEA	OTHER:)				
¥	1 YES 2,77 NO	1 Management 2 ☐ ER/Outpa 28a, OATE OF INJURY				6 Other (Specify			
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIM INJ	URY W	JURY AT ORK?	28d. OEŞCRIBE H	OW INJURY OCCU	JREO	
B	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY	- At home farm		YES 2 NO	201 LOCATION (C	book and blook as a		
COMPLETED	4 Homicide 8 Could not be	building, etc. (Specif	(y)	meet, lectory, only		City or Town,	State)	r Rural Route Number,	
9	29a. CERTIFIER	AM. To the best of our first		a localii teni	77. manufactur n	-15 10 2-10			
M M		AN: To the best of my knowle						f. cause(a) and menner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER		and of the carge to					10115	
H		orland,	- mo		DOG	MBER O G	29d. DATE :	SIGNEO (Month, Day, Year)	
임	30. NAME AND ADDRESS OF PERSON WHO				100	010	1001	VEMBER 15, 1993	
	ANDREW NOW,	AKOWSKI,	MD	/25					
	NUV 1 6 1995	, REGISTRAR'S IGNA	TURE						

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN REG. NO.	Ε ,	3 34000
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	Y - YEA	3. TIME OF DEATH
Ĥ	BERN:		(in yrs. lest birthday)	risoff	[NÖVEMBER		
	215-18-9176	1 🗆 M 2 🙀 F	73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APR. 7,19		RYLAND
OR	99. FACILITY NAME (If not institution, give stre 7 RISES COURT	et and number)			OR LOCATION OF DE	EATH	9c. COUNTY O	OF OEATH ALTIMORE
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. C/1	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
		ALM BEACH	1	DELRAY B				1 X YES 2 NO
RAL	100. STREET AND NUMBER 14460 STRATHMORE	IANTE DIDC	S ADM '		7. ZIP CODE 33446	5	10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL		12. WAS DECEDENT EVER I	IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Yes	or No- 14. I	RACE — American Indian,
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			pecify Cuban, Maxica S 2 X NO Specif	in, Puerto Ricen, etc.) y:	1	Specify: WHITE
	15. OECEDENT'S EDUCA	ATION	16a. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BUS	SINESS/INDUST	
COMPLETE	(Specify only highest grade of Elementery/Secondery (0-12)	completed) College (1-4 or 5+)		work done during n		Baltimo		
MPL		1	EX	ECUTIVE	SECRETAR!	Y DALTIMR	HEBR	EW COLLEGE
	17. FATHER'S NAME (First, Middle, Last)		COL DEET	¥		ME (First, Middle, Maiden	,	T 7704
BE	WILLIAM 19e. INFORMANT'S NAME (Type/Print)		GOLDFEII		LEI and Number or Rural			LUM
2	JACK	MATISOFF	14460	STRATH	MORE LANI	Route Number, City or Tow BLDG 6, AI	PT. 202	FL 33446
	20e. METHOD OF DISPOSITION 1 1 Burtel 2 Cremetion 3 Remove		b. PLACE AND DATE		UK AMUNO	DATE 20c. LO	CATION - City	
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	The second secon	ALDING10			& BROS.,		11101111/1110
Û	▶ allensue	Levens	200					ORE, MD 21215
	23. PART I. Enter the diseases, or co shock, or heart fellure. L	omplications that cause lat only one cause on	d the death. Do each line.	not enter the m	ode of dying, auc	th as cardiac or respi	ratory arrest,	Approximeta Intervel Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	metas	raic)	In Sm	20 Cell	2 Line Ca	n les	Onset and Death
		DUE TO (OR AS	A CONSEQUENCE O	OF):				
NO	Sequentially list conditions, if any, leading to immediate		A CONSEQUENCE O	OF):				
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury							
THE	thet initieted events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE ()F):				
CER	d.	•						
SAL	PART II. Other significent conditions	contributing to deeth	but not resulting	in the underlyi	ng ceuse given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDIC						1 YES 2	(PNO	OF DEATH?
Σ	DID TOBACCO USE CONTR	IBUTE TO CAUSE (OF DEATH Y	ES NO	UNCERTAL	ND		1 TYES 2 THO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	ATH (Check only on)			
IXSI	1 TYES 2 T NO	1 Inpatient 2 ER/Out				6 Other (Specify)		
	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)		JURY W	URY AT ORK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURE	D
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJUR building, etc. (Spi	Y — At home, term,	street, factory, off		281. LOCATION (Street City or Town, State)	end Number or R	ural Route Number,
ш	4 Homicide detarmined					Only or rown, ciercy		
COMPLET	onel	CIAN: To the bast of my known: 3: On the basis of examination						use(e) and menner se stated.
	296. SIGNATURE AND TITUE OF CERTIFIER	A	11 1		29c. LICENSE NU			SNED (Month, Day, Year)
TO BE	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	Under	- Print)	D1720	07	P []	13/95
	DAVIDS ETTIN	GERIND.	The John	s Hapkin	5 Ducolage	(entor a	Aotta	10 21287
	NOV 1 6 1005	72. REGISTRAR'S SIG	Charlett		•			

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FINERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	r death. Page 6 may be retained by the hospital or attending physician. It funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be funeral director, page 5.
De med within 72 nouts aret death with the state uept, or regulation whilst hybere prior to burke, crembout, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	examiner must be notified at once.
TO BE COMD! ETED BY DHYSICIAN: MEDICAL CEDTICION	TO BE COMPLETED BY CLINEDAL DIDECTOR

TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
1. DECEDENT'S NAME (First,	Middle, Last)				MCCAN	75	2. DATE OF DE		1905	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	R	5. SEX		s. last birthday)	IF UNDER 1 YEA		7. DATE OF BIR (Month, Day,		Count	
251-14-2622 9a. FACILITY NAME (# not ins	Watton also et	1 X M 2 F	74	YRS.		N OR LOCATION OF D	9/ 29/		_	TH CAROLINA
GOOD SAMARIT	IAN HO					LTIMORE	JEATH	9c. CC	BALTII	MORE
RESIDENCE OF DECI	10b. COUNTY			10c, CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY
MARYLAND	BALT	IMORE			BALTIMO					LIMITS? 1 X YES 2 NO
6527 LOCK H	II.I. RO)AD				101. ZIP CODE 2123	39	10g. C	U.S.	WHAT COUNTRY?
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S	. ARMED	13. WAS I	DECENDENT OF HISPA	NIC ORIGIN? (Spec	cify Yea or No-	- 14. RACI	E — American Indian.
1 Never Married 2 1 1 3 Widowed 4 Divor	Married ced	FORCES? 1				epecify Cuban, Maxic YES 2 NO Spec		ile.)		k, White, atc.
(Specify only	DENT'S EDUC highest grade	CATION completed)	164		USUAL OCCUP		18b. KIND	OF BUSINESS/I	NDUSTRY	
Elementary/Secondary (0-	12)	College (1-4 or 5	+)	_	BORER			UNK	NOMN	
17. FATHER'S NAME (FIRST, MIC MOSES MCCANT						18. MOTHER'S N	AME (First, Middle, I	Meiden Sumeme TS)	
19a. INFORMANT'S NAME (Ty)		CANTO		196. MAILING	ADDRESS (Stre	et and Number or Rural	I Route Number, City	or Town, State,	Zip Code)	21239
REV. JAMES	ON		20b. PL/		OF DISPOSITION			Oc. LOCATION		
1 X Burlal 2 Cremation 4 Donation 5 Other		oval from State	cemeter)	y, crematory or c	cher place) CHURCH	L CEMETER'	Y 11/15	95 FL	ORENC	E,S.CAROLINA
21. SIGNATURE UNLERAL	SERVICE LIC	PA A				BROTHER		I HOME		
Jung	VI	Teser	1/		1300	EUTAW PL	ACE BALT	IMORE.		AND 21217
23. PART I. Enter the disabook, of ha IMMEDIATE CAUSE (Fine disease or condition resulting in death)	art failure, l	List only one cal	REBRI	lina.	ULAR	ACCIDE		reapiratory	arreat,	Approximate interval Batwean Onset and Daeth
			(01. 43 4 00	NSEO DENCE O	,					
Sequentially list condition if any, leading to immed cause. Enter UNDERLY	lata	DUE TO	(OR AS A CO	NSEGUENCE O	F):					
CAUSE (Disease or Injur		DUE TO	(OR AS A CO	NSEQUENCE O	OF):			-		
reaulting in death) LAST		d								
PART ii. Other significer	t condition	a contributing to	death but r	not reaulting	in the underi	ying cause givan i		MAS AN AUTO	241	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
								YES 2 NO		COMPLETION DF CAUS OF DEATH?
DID TOBACCO US	SE CONTE	PIRUTE TO CA	USE OF I	ΣΕΔΤΗ Y	FS 🗆 NO	☐ UNCERTA	IN P1			1 TYES MO
25. WAS CASE REFERRED TO					ATH (Check only o					
EXAMINER? 1 YES 2 NO		HOSPITAL:	ER/Outpatlar	nt 3 🗆 DOA	OTHER:	ioma 5 🗆 Raaldence	6 Other (Spec	ify)		
27. MANNEY OF DEATH 28a. DATE OF INJURY (Month, Day, Vear) 28b. TIME OF INJURY AT WORK? M 1 YES 2 ND										
2 Accident Investigation 3 Sulcida 8 Could not be 4 Homicide detarmined 28e. PLACE OF INJURY — Al homa, farm, straal, factory, offica building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
29b. SIGNATURE AND TITLE	OF CERTIFIER	MISE M	EFIRE	R		29c. LICENSE NO	UMBER	29d. D	ATE SIGNED	(Month, Day, Year) 1) 1995
30 NAME AND ADDRESS OF	PERSON WHI	O COMPLETED CAU	SE DF DEATH	(ITEM 27) (Type		0-1-	RITAN	114-	000	- 1111/
31. DATE FILED (Month, Opy.)	(m) di	3). REGISTR	IR'S IGNATU	PI)	(5001)	SAMA	K 1/XTV	MUSI	111	97_

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MARYLAND 21215-002	attending
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TIMORE	may be
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Σ	Page
BALT	death.
00	BL C

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Pages 1, 2, 3

permit.

ached for use as the burial-transit

once.

2

TASNEEM

NOV1

31. DATE FILEO (Month, Day, Year)

6 1995

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,) Print)

Juli

KHANI

32. REGISTRAR'S SIGNATURE

7220

HARK

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be det	2	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle 2. DATE OF DEATH 3. TIME OF DEATH $A_{\mathbf{M}}$ 5:30 now 1995 4. SOCIAL SECURITY NUMBER (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 2/18/190 8 12 1 - M 2 X F 5 Vergenea TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY BALTIMORE BALTIMORE 1 YES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2840 OAKFORD AVENUE 21215 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: Never Merried 2 Merried Specify: BLACK 3 Widowed 4 Divorced BY ETED. 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) COMPL HOMEMAKER HOME Λ 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname WERT C. PERKINS LAURA JONES PERKINS BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DANNY McKOY 2840 OAKFORD AVENUE BALTIMORE, MARYLAND 21215 20a. METHOD OF DISPOSITION
11√ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) _ HOLLY HILLS CFMFTFRY 11/11/95 BALTIMORE, COUNTY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME PA. 1300 FUTAW PLACE BALTIMORE MARYLAND 21217 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiec or reepiratory erreet, Approximete shock, or heert fellure. List only one ceuse Interval Betwe IMMEDIATE CAUSE (Finel Onset end Death diseese or condition EVVIC month resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF). CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO)0N EPEN) FOR NSU LIN 1ABGTES MERUTY.S COMPLETION OF CAUSE DF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 - Residence 8 - Other (Specify) 40 1 27. MANNER OF OEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) and menner so ateled. SIGNATURE AND TITLE OF CERTIFIER LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) ш 0 011

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BALTI

VE

3. TIME OF DEATH

10d. INSIDE CITY

Specify:

1 X YES 2 NO

Black

21207

Approximate

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

interval Between

Onset and Death

4:05 PMM

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE

REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

£ 1995

68760.
ВОХ
P.0.
RECORDS,
OF VITAL
DIVISION

2. DATE OF DEATH Curlie YEAR Mason 11 10 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) June 7, 5. SEX IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 1 M 2 🗆 F DAYS HOURS 45 YRS. Washington, DC 1950 use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR VA Hospital Baltimore n/a RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland n/a Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5214 Norwood Avenue 21207 USA Page 6 may be retained by the hospital or attending physician, al director, page 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indien, Black, White, etc. FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES ULY 70 — AUG ' 1 Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Ricen, etc.) BY 1 YES 2 X NO Specify 3 Widowed 4 Divorced July COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp. Elementary/Secondary (0-12) College (1-4 or 5+) High School Barber Mason House of Styles 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Curlie W. Mason Katherine Gray BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Curlie Mason, Sr. 5214 Norwood Avenue Baltimore, Maryland Pe 20e METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (. 20c. LOCATION — City or Town, State NOV must Baltimore National Cemetery14 4 Donation 5 Other (Specify) Owings Mills, Maryland examiner 21. SIGNATURE OF FUNGRAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway the funeral ours after death. seven a. Baltimore, Maryland 21216 filled in by the fion, or removal, medical 23. PART i. Enter the dieeeees, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. Liet only one cause on each line. **IMMEDIATE CAUSE (Fine)** cremation, the diseese or condition executed within Cancer with Metastasis completely Pancreatic event, 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF) bunal traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) Hygiene prior to if any, leeding to immediate cause. Enter UNDERLYING attending physician certificate be other 1 CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST 10 the death signed by the atter Health and Mental injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? requires that shows any 1 TYES 2 NO has been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO PHYSICIAN: W.P. Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one The Item this certificate State HOSPITAL:

1 X Inpetient 2 - ER/Outpetient 3 - DOA OTHER: TO THE HOSPITAL OR ATTENDING PHYSICIAN:
TO THE FUNEPAL DIRECTOR: After this certifica
be filed within 72 hours after death with the Ste
IMPORTANT: If Item 28 is marked, or It 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be COMPLETED 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. (Check only one) 2 MEDICAL EXAMINER: OF the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated. MONATUME AND TITLE OF CERTIFI 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 11/10/95 hm 2 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

00.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERTIFIC	CATE O	FDEATH	Ri	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) TRINA	Yvette		М	CCULL	IIM	2. DATE OF O	ER 10,	1 0 0 5	3. TIME OF OEATH 19:15	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. le		F UNDER 1 YEA		7. DATE OF B				
	219-76-8739	1 □ M 2 🂢 F		4 YRS.	ONTHS DAY	S HOURS MIN.	July 2	4, 1971	Cour	8. BIRTHPLACE (State or Foreign Country) Maryland	
· ·	9e. FACILITY NAME (If not institution, give			9		N OR LOCATION OF D		9c. C0	DUNTY OF	OEATH	
DIRECTOR	THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY										
S	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									10d, INSIDE CITY	
告	Maryland	n/a		F	Baltim	ore				LIMITS?	
A	10e. STREET AND NUMBER				T T	101. ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?	
ER	1668 Mountmor Co	urt				21217			US	. Δ	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. A	RMED	13. WAS 0	DECENDENT OF HISPA	NIC ORIGIN? (Sp	ecify Yea or No-	14. RAC	E - American Indian,	
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1		NO		specify Cuban, Maxico		, etc.)	Spe	ck, White, etc.	
					1		-			Black	
TEO	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	(0	ECEDENT'S US	k done during	ATION most of working	18b. KIND	OF BUSINESS/	NDUSTRY		
ET.	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	e. Do NOT use r							
COMPL		Trade 1yr		uner	ploye			n/a			
- 1	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA)		
띪	George McCullum 19a. INFORMANT'S NAME (Type/Print)						h M. Wi				
2	ACTION OF THE PARTY OF THE					et and Number or Rural					
	Emogene Williams					ok Road	7	A Ba			
	20a, METHOO OF DISPOSITION 1	noval from Stata	cemetery, cri	and DATE OF	place)	1 Park	TNOA	20c. LOCATION			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE /	ALDU	cus ne	22 NAME	AND ADDRESS OF E	CHITYATALL	Baltimo	ore C	ounty, MD	
	\$ 17	1			25	01 Gwynns	Falls	er Fune Parkway	eral	Homes, Inc	
0	2501 Gwynns Falls Parkway Baltimore, Maryland 21216										
1	23. PART i. Enter the diseases, or shock, or heart failure.	complications that ca List only one cause	on each line	eath. Do not e.	enter the	mode of dying, suc	h se cardiac d	or respiratory	arrest,	Approximata Interval Between	
4	IMMEDIATE CAUSE (Final	0	1	1.9						Onset and Dea	
	disease or condition resulting in death)	BUE TO (OR	ratory	tail	ure					19 days	
		DUE TO (OR	AS A CONSE	OUENCE OF):						01	
S S	Sequentially list conditions,	b. Meun	AS A CONSE	1 pm	ewnor	110				Odays	
CATION	if sny, leading to immediate cause. Enter UNDERLYING	ATN	AS A CONSE	OUENCE OF):						4.00-	
	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR	AS A CONSE	OUENCE OFI:						Tyears	
CERTIFI	resulting in death) LAST										
		d									
DICAL	PART II. Other aignificant condition			11		ring cause given in	Part i. 24a.	WAS AN AUTOPS PERFORMED?	Y 24	b. WERE AUTOPSY FINDING	
음	Meumococcal	Sepsis,	oneun	no thon	at		1□	YES 2 KNO		COMPLETION OF CAUSE OF DEATH?	
ME										1 YES 2 NO	
	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEA	ATH YES	☐ NO	■ UNCERTAIL	N 🗆				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEATH		ne)					
YS!	1 - YES 2 7 NO	1 Inpatient 2 ER	VOutpatient 3		THER:	ome 5 🗆 Rasidenca	8 Other (Spe	cify)			
PHY	27. MANNER OF DEATH	28a. DATE OF INJ (Month, Day, Y		28b. TIME C		INJURY AT WORK?	28d. DESCRIB	E HOW INJURY O	CCUREO		
B	1 Natural 5 Pending 2 Accident Investigation					YES 2 NO					
	3 Suicide 8 Could not be determined	28s. PLACE OF IN building, etc.	IJURY — At he (Specify)	ome, farm, stre	et, factory, of	ffica	28f, LOCATION City or Tow	(Street and Number, State)	per or Rural	Route Number,	
<u>E</u> E											
교		ICIAN: To the best of my									
COMPLI	one) 2 MEDICAL EXAMINE	ER: On the beats of exemi	ination and/or	Investigation, I	In my opinion	n, death occured at the	time, data and p	place, and due to	the cause(a) and manner as stated.	
BE C	296. SIGNATURE AND TITLE OF CENTIFIE	R	1		-	29c. LICENSE NUI	MBER	29d. O.	ATE SIGNE	O (Month, Day, Year)	
OBI	Danit	1	U			NZ2	YT	> /	Voven	ber 10 19	
ĭ	30. NAME AND ADDRESS OF PERSON WH	NEER M		Jahns		Heall	R.H.	29d. 0.	10		
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31. DATE FILED (Month, Day, Year)
NOV 1 6

I	1. DECEDENT'S NAME (First, Middle, Last	() .—			CATE OF			OF DEATH		3. TIME OF DEATH
	ROBERT	E			noore	, S <i>R</i> ,	NOV 6	MBER		4:301
	4. SOCIAL SECURITY NUMBER 250-20-3156	5. SEX 6. A	AGE (In yrs. le:		IF UNDER t YEAR	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH		BIRTHPLACE (State or Fore Country)
	9e. FACILITY NAME (If not institution, give		70	THS.	9h CITY TOWN	OR LOCATION OF D		24,		Iorth Caroli
5	4866/66th Avenue	,			Hyatts		ZEAIN			e George's
DIMECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	ITY		10c CITY	TOWN OR LOCA	TION			Tranc	
2	Maryland Pro	ince George'	5		attsvil					10d. INSIDE CITY LIMITS?
¥.	10a. STREET AND NUMBER				10	of, ZIP CODE				EN OF WHAT COUNTRY?
FUNERAL	4866 66th Avenue	12. WAS DECEDENT EV	FRINTIS A	PMED	12 MMC DE	20784 CENDENT OF HISPA	ANC ORION	0 00 14 · V		S.A.
_ 11	1 Never Married 2 Merried	FORCES? 1 X	YES 2		If yes, s	pecify Cuban, Mexic S 2 XNO Spec	en, Puerto F	Rican, atc.)	es or No—	4. RACE — American Indien Black, White, etc. Specify: White
ה פֿל	3 Widowed 4 Divorced 15. DECEDENT'S ED	NICATION	40.00							
	(Specify only highest gra-		(0		JSUAL OCCUPATI ork done during m retired.)		16b.	KIND OF BI	USINESS/INDUS	STRY
- J III	, (0 12)	5511090 (1-4 51 5 4)					A	ir Fo	orce	
COMP	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N	AME (First, A	Aiddle, Meide	n Surname)	
#	19e. INFORMANT'S NAME (Type/Print)	(son)	19	b. MAILING	ADDRESS (Street	and Number or Rural	I Route Numb	er City or To	um State Zin C	Cordel
۵	Ronald Moore					Road-Hya				
	20a. METHOD OF DISPOSITION 1	moval from State		AND DATE OF	F DISPOSITION (N	lame of	OATI	20c. L	OCATION CII	fy or Town, State
H	4 10 Donallon 5 Other (Specify)	LICENSEE RONALd				NO ADDRESS OF F	ACH ITY			
- 1	A 2011	Las	wate,	000.	State	Anatomy	Boar	d-655	W. Ba	iltimore Str
	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. List only one cause o	on each line	.	ot enter the me	ode of dying, au	ch as cerd	lac or resp	piratory arrea	Interval Bet Onset and
TIFICATION	snock, or heart failure immediate cause. Enter UNDERLYING CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	e. Generalization e. Generalization e. Generalization DUE TO OR DUE TO (OR DUE TO (OR	ATA AS A CONSE	OUENCE OF	leastic	ode of dying, au	ch as cerd	lac or resp	piratory arrea	Approximation interval Bet Onset and I
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1 - STATE

UNKNOWN 95-223
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REG. NO.

	REGISTRAR		<u>C</u>	EULILI	CAIL	JE DEF	VI III	HEG. NO.				
	1. OECEDENT'S NAME (First, Middle, Last) Doris Theresa Moc	re- MILLER	R				11	2. DATE OF DEATH SEPTEMBER	11	WEAR !	3. TIME OF DEATH 5 01:01A M	
	4. SOCIAL SECURITY HUMBER 214-86-6800	5. SEX 1 M 2 X F	6. AGE (In yrs. Is 28		IF UNDER 1 YE	AR IF UND	ER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) April 11.	1967	8. BIFTHP Country	ND	
	9e. FACILITY NAME (If not institution, give :				9b. CITY, TO	WN OR LOCA	TIOH OF D			ITY OF DE	ATH	
5	the state of the s	500 BLK. CHESTNUT HILL AVE.					BALTIMORE N/A					
3	10s. STATE 10b. COUNT	OCATION				-	10d, INSIDE CITY					
	Maryland			Ва	ltimo						LIMITS?	
ONE PAR	1504 Plum Street					101. ZIP CO	1226		_	ZEN OF WI	HAT COUNTRY?	
	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A	RMED	13. WAS			NIC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indian,	
	1 Never Married 2 X Married 3 Widowed 4 Divorced	Never Married 2 X Married FORCES? 1 ☐ YES 2 XNO IF YES, DIVE WAR OR DATES						an, Puerto Rican, etc.)		Bleck, Specify	While, etc. Black	
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L L	17. FATHER'S NAME (First, Middle, Last)					4	THER'S N	AME (First, Middle, Meiden	Sumame)			
	David Moore					- 1		HARVEY	,		1.0	
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2	David Moore							timore, Mar			1 237 21218	
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			- G/	ARRISON	FORRES			11/21/95 OWIN				
	21. SIGNATURE OF FUNDRAL SERVICE LI	censee Ronal	d Wade,	Dir.	Sta:	E AND ADDI	tomy	EIGAPARKOHET	JONE SHTS, A	S FUNE	RAL HOME NOTOCHARTESTS 11-1559	
	ahock, or heart failura. MEDIATE CAUSE (Final disease or condition resulting in death)	Gere	(OR AS A COHS	hour	Js .	of H	ead	land L	eg		interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	(OR AS A COHS									
DICAL C	PART II. Other algnificant condition	ns contributing to	death but not	resulting i	n tha unda	rlying caus	a givan ir	PERFO		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
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0	2 Accident Investigation	28 PLACE C	F IHJURY — At	home term s				28f, LOCATION (Street	and Number	or Bural B	oute Number	
1	3 Suicide 8 Could not be determined	building.	atc. (Specify)	TRE	ET	, ornes		SOU BIL	Le	str	+ Ave	
COMPLETE	(Critical Orley							se to the cause(a) and ma			-	
5	2 XMEDICAL EXAMIN	ER: On the beals of a	xemination and/o	or Investigatio	n, in my opir	ion, death oc	cured at th	e time, data end placa, er	nd due to ti	he cause(a)	and manner as stated.	
חם	29b FIGNATURE AND TITLE OF CERTIFIE	en ork	0 1	W)	_		. C . M		29d. DAT		(Month. Day. Year)	
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAU	SE OF ATH (T	тем 27) (Туре, 11 Р	enn S			Baltimore				
	31. DATE FILEO (Month, Day, 186r)		AR'S SIGHATURE						····	_		
	NOVA P 186	E Chi	Murchant	Tan-11								

TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: 11

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2. be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MDORTANT Hism 28 is marked or Hem 23 shows any injury or other traumatic event the medical examiner must be notified at once

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

S NAME (First, Middle, Last)									
COLUMN TOTAL AND LANDINGS	TCHELL				2. DATE O	DAY	1995		ME OF DEATH
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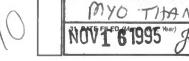
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 10 1995 November 11:00 AM M McCarty Susan 4. SOCIAL SECURITY NUMBER 5 SEX 6. BIRTHPLACE (Stete or Foreign 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH August 11 DAYS HOURS 1 M 2 X F 215-64-8740 41 1954 Maryland 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6816 Bessemer Avenue Dundalk Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maruland Baltimore. Dundalk 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7535 Berkshire Road 21222 United States 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO If yes, specify Cubs
1 ☐ YES 2 ☑ NO an, Mexicen, Puerto Ricen, atc.) 1 Never Married 2 X Merried Specify. ΒY 3 Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 3 Years Secretary Banking 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) Arthur Howard Kirk Agnes Mabel Reuschling BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. 7535 Berkshire Road Dundalk, Maryland Brian L. McCarty. 21222 20e. METHOD OF DISPOSITION

1 Burlel 2 Cremailon 3 Ramoval from State
4 Donation 5 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE remotery crematory or other piece)
Hilltop Service Corp. 11/13/1995 Towson, Maryland 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 23. PART I. Enter the diseases, or complications that sused the death. Do not enter the mode of dying, such as cerdiac or raspiretory arrest, Approximate Interval Between shock, or heert tailure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel Onset and Death diseese or condition Metastuhe
DUE TO (OR AS A CONSEQUENCE OF): Porcent Canca reaulting in deeth) 43 CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST PART ii. Other eigniticent conditione contributing to death but not recuiting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 TAN 1 - YES 2 -DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | WNCERTAIN | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Sesidence 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 284 DESCRIBE HOW INJURY OCCURED 1 Netural 1 YES ВҰ 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner es atated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(s) end menner es stated.

29c. LICENSE NUMBER



BE

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29b. SIGNATURE AND TITLE OF CERTIFIER

m

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

9101

FRANKLI

29d. DATE SIGNED /M

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FERRO

32. REGISTRAR'S SIGNATURE

FERNANDO

31. DATE FILED (Month, Day, Year)

NOV 1 6 1805

hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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Pag	ल	ner
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 124 hours after death. Page 6 m	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, he find within 72 hours after death with the State Dent or Health and Mental Harlese nrind in budal companion or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner mus
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OR	DIRE	Hem
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HOS	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi he fined within 72 hours after death with the State Dent of Health and Mental Houlene prior to build resemble or seminal	TAN
IF	THE	POR
2	22	E

											95	34	645
	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	TMENT	OF HI	EALTH DEAT	AND N		YGIENE	1		
	1. DECEDENT'S NAME (First, Middle, Lest) MICHAEL	HOWELL	MONTA						2. DATE OF MONTH	DEATH DAY	19	YEAR 3.	TIME OF DEATH 8:00 A M
	4. SOCIAL SECURITY NUMBER 219-40-2036	5. SEX	6. AGE (In yrs. las	t birthday) YRS.	IF UNDER		IF UNDER	24 HRS.	7 DATE OF		T	6. BIRTHPL	ACE (State or Foreign
N.	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT										ITY OF DEAT		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION									d. INSIDE CITY .
	MARYLAND 100. STREET AND NUMBER		BALTIMORE								1	VES 2 NO	
FUNERAL	214 N. SPRING				101.	ZIP CODE	= 2123:	1			TED	STATES	
₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDEN FORCES? XI IF YES, GIVE V	T EVER IN U.S. ARI	MED IO	11	yes, spec	Ify Cuba	F HISPAN n, Maxicar Specify	IC ORIGIN? (5 n, Puerto Rice	Specify Year n, atc.)	W No-	14. RACE — Black, W Specify:	American Indian, /hite, atc. BLACK
TED	15. DECEDENT'S EDUCI (Specify only highest grade of	ompleted)	(GI	CEDENT'S ve kind of a Do NOT us	USUAL OC	CUPATION uring most	of workin	9	16b. KII	ND OF BUSI	NESS/INO	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 -		ABOR						BRICK	YAR	D	
TO BE COM	17. FATHER'S NAME (First, Middle, Lest) GEORGE MONTA	GUE					18. MOTH		ME (First, Midd ALDINE		umame) EWMAN	l	
TO B	19a, INFORMANT'S NAME (Type/Print) GERALDINE MC	NTAGUE,	GEORGE 196	214	ADDRESS	(Street and	Number	or Rural R	OURT,	BALTI	Since Zip of	, MD	21231
must be	20g, METHOO OF DISPOSITION 1 A Burial 2 Cremetton 3 Remon	ral from State	20b. PLACEA cometery, creating					254	OATE	1		City or Town,	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSES /	GARRI	<u> 2014 </u>	22. N	IAME AND	ADDRES	CEM.	YTLIE		IINGS	MILL	.5,140
	23. PART I. Enter the diseases, or co	LARD.	t payed the de	oth Do					FH1			NORTH	
me mence	IMMEDIATE CAUSE (Final	let only one cau	se on aach lina				e ot dyl	ng, such	n as cardiad	or respira	itory arre	est,	Approximata Interval Between Onset and Death
rvent, ti	disease or condition resulting in death)	OUE TO	(OR AS A CONSEC	OUENCE OF	4058 Fi:	75							years
NOL	Sequentially list conditions, if any, leading to immediate		(OR AS A CONSEC			iou	5						years
ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSEC	UENCE OF	ም :								
	resulting in death) LAST												
ICAL O	PART II. Other significant conditiona AIDS	contributing to	daath but not re	asulting l	n tha unc	lariying	cause g	iven in i	Part I, 24	PERFORM	ED?	AVI	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE
PHYSICIAN: MEDICAL										YES 2	₹NO	OF	DEATH? YES 2 NO
IAN:	DID TOBACCO USE CONTR	BUTE TO CA			H (Check or		UNC	ERTAIN					
IVSIC	1 TYES 2 NO	HOSPITAL:				ng Home	-	sidenca t	KOther (Se	oecity) HOS	SPICI	E	AT MERCY
BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D		28b. TIM	E OF URY M	28c. INJUI WORI	RY AT K? S 2 _	NO NO	28d. OEŞCRI	BE HOW INJ	URY OCCL	URED	
	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE O building,	F INJURY — At horate, (Specify)	me, farm, s	straat, facto	ry, office			28f. LOCATIO City or To	N (Street and wn, State)	1 Number o	or Rurai Route	Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI												d manner as stated.
BE CC	29b. SIGNATURE AND TITLE OF CERTIFIER	Usm					29c. LICE	NSE NUM	BER				onth, Day, Year)

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1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

		REGISTRAR		CERTI	FICATE (OF DEATH	REG. NO).			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN			TIME OF DEATN	-
		RAYMOND	N	IELSO	3M		NOVE MBER	11 19	GAR QS	9-15 0	M
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday		AR IF UNDER 24 HRS.	7. DATE OF BIRTH			ACE (State or Foreign	301
		217-05-7719	1 M 2 D F	95 YRS.		WS HOURS MIN.	(Month, Day, Year)		Country)		
should		9a. FACILITY NAME (If not institution, give st	7.7	95	01 OVEN TO		pct 10, 19		_	ginia	
3 sho	ac					WN OR LOCATION OF D	DEATN	9c. COUNTY	OF DEAT	N	
6	2	Liberty Medical	Center		Ba]	Ltimore		<u> </u>	n/	a	
8 -	DIRECTOR	10a. STATE 10b. COUNTY	v	10c. C	ITY, TOWN OR L	OCATION			I 40		
permit. Pages	E			100. 0.					- 1	d. INSIDE CITY LIMITS?	
Ĕ		Maryland n	/a		Baltin					YES 2 NO	_
	FUNERAL					10f. ZIP CODE		10g. CITIZE	OF WHA	T COUNTRY?	
020 physician. burial-transit	19	3901 Fairfax Roa	<u>d</u>			21216		U	SA		
215-0020 attending physician se as the burial-tra	5	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS	DECENDENT OF NISPA	NIC ORIGIN? (Specify Yes		RACE -	American Indian,	
215-0020 attending physic ise as the burial	BY F	1 Never Married 2 Married 3 X Widowed 4 Divorced	IF YES, GIVE WAR OR D			s, specify Cuben, Mexic YES 2 X NO Speci			Black, W Specify:	hite, etc.	
15-0 ending as the		3 X Widowed 4 Divorced				-	.,,		open,	Black	
	9	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT	'S USUAL OCCU	PATION	16b. KIND OF BUS	SINESS/INDUS	TRY	/	
21 21 6 u		Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	use retired.)	g most of working					
Ded spita	릴	8th Grade		Truck	Driver	-Rigger	George	Trans	for	Company	
AND 21 the hospital or detached for u	COMPLET	17. FATNER'S NAME (First, Middle, Lest)		11 40.1	DETACE		AME (First, Middle, Maiden		I CI	Company	-
YLAND by the hospit be detached at once.		Alexander Nelson						Sumamej			
Par par	BE	190. INFORMANT'S NAME (Type/Print)		T		Blanch					
MAR retained to 5 should notified	일						Route Number, City or Tow				
E, N y be r y be r		Ada B. Smith			Fairfa		Baltimore	, Mary	land	21216	
may be or, page		20s, METNOD OF DISPOSITION 1 [2] Burlel 2 Cremation 3 Finance	20b	PLACE AND DATE	E OF DISPOSITIO	N (Neme of	NOV 20c. LO	CATION - City	or Town,	State	
The G		4 Donation 5 Other (Specify)		odlawn (Cemeter	y	16 Bal	timore	Cou	nty, MD	
Pag in all di		21. SIGNATURE OF FUNERAL SERVICELIC			22. NAM	E AND ADDRESS OF F				omes, Inc	
BALTIMORE, MARYLAND sir death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached val. Il examiner must be notified at once.		1 A TU	C		250	1 Gwynns	Falls Park	Man	ar ir	Ollies, Inc	
BALTIMORE, nours after death. Page 6 may be of in by the funeral director, page or removal.	-	2 mars 1	comy		Ba1	timore, M	arvland 2	1216			
e e		23. PART I. Enter the diseases, or c shock, or heart failure. I	complications that ceused List only one cause on e	I the deeth. Do	not enter the	mode of dying, suc	ch aa cardiec or respi	iratory arrest	,	Approximate	
		IMMEDIATE CAUSE (Finel		1						Interval Between Onset and Deatl	
		disease or condition	LIVER 1	LAIL	Dre.				1911		
1760 ted within completely fal, cremati		resulting in deeth)		CONSEQUENCE							_
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execute to pur to bur t	ó	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE		un of "	TE NICL				_
S iciai G	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING			or,.						
	5	CAUSE (Disease or injury	DIE TO (OR AS A	CONSEQUENCE (_
P.O. E th certifical anding phy Hygiene I or other	Ē	that initiated events resulting in death) LAST	DOE TO (OH AS A	CONSEQUENCE	OF):						
요 등 등 등 등	55		d								
ORDS, F that the death ed by the atter th and Mental any Injury, o		PART ii. Other significent conditions	s contributing to deeth b	ut not resulting	in the under	ving cause given in	Part I. 24s. WAS AN	ALITODEV	245 WE	RE AUTOPSY FINDINGS	-
ORI that the ed by th and	EDICAL		_			, mg daddo given in	PERFOR		AWA	VILABLE PRIOR TO	
ECO quires that signed Health a ows an)	ā						1 🗀 YES 2	-NO		MPLETION OF CAUSE DEATH?	
REC requires been sign of Heat	ž						/		1 [YES 2 TO	
. 3 5		DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH Y	ES 🗌 NO	□ UNCERTAI	N 🗗				
AL he lan e has te Deg	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE	ATH (Check only	one)					
VIT.	S	1 YES 2 NO	HOSBITAL: 1 Inpatient 2 ER/Outp	estient 3 DOA	OTHER:	Nome 5 Residence	E Char (Passible				
the the	₹	27. MANNER OF DEATN	28a. DATE OF INJURY	28b. Til	-	INJURY AT	28d. DESCRIBE NOW II	N BIRV OCCUR	50		
NG PHYS frer this eath with		1 Natural 5 Pending	(Month, Day, Year)	IN	JURY	WORK?	200. DESCRIBE NOW II	NJUNT OCCUM	EU		
ONG DING After death death	B	2 Accident Investigation				YES 2 NO					
DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is mai	8	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spec	At home, farm,	, atreet, factory,	offica	28f. LOCATION (Street a City or Yown, State)	and Number or I	Rural Route	Number,	
OR ATTEN OR ATTEN DIRECTOR: hours after tem 28 I	<u> </u>	Tomoto Garanina									
DIN OR /	7 1	29a. CERTIFIER (Check only	CIAN: To the bast of my knowl	ledge, death occur	rred at the time,	data and place, end du	to the cause(a) and man	nner as stated.			
PITAL ERAL 7. 11	COMPL		R: On the basis of examination						tune(a) en	d manner as stated	
TAN ITHIN		29b. SIGNATURE AND TITLE OF CERTIFIER									
TO THE HOSPITAL TO THE FUNERAL be filed within 72 I	H	296. SIGNATURE AND TITLE OF GENTIFIER				29c, LICENSE NU	MBER	29d. DATE SI	GNED (Mo	nth, Day, Year)	
, 223 X	2	_ Duan are	al 5M.D.			0-18	933	▶ //-	11- 9	'	
/	- 1	/ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typ	e, Print)		1 /				Π
/		DUAN RF PF	AREdes 2	2600	Hood	1 Hert	BOLTMONE	MD	210	2/5	
		31. DATE FILED (Month, Day, Year)	32 BEGISTRAR'S SIGN	ATURE		-					٦
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CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ola 130 Nov 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. (Month, Day, Year) 01-29-0 Maryland Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Meridian Nursing Center Catonsville DIRECTOR Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Baltimore MD Catonsville 1 YES 2 X NO permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? N. Beaumont Avenue USA Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 21228 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES В White 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 166. KIND OF BUSINESS/INDUSTRY the funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Homemaker Own Home once. 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) John Spencer McKay notified at Alice May Holler BE 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. INFORMANT'S NAME (Type/Print) Jeane Beere (Daughter) 7013 Carmae Road Sykesville, Maryland 21784 pe 20e. METHOD OF DISPOSITION
M Suriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Algree of cemetery, cremetory or other place) NOV. 15, 1995 20c. LOCATION — Cify or Town, State must Loudon Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) _ medical examiner 21. SIGNATURE OF SHIP AL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes LEARCE CE 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, completely filled in by shock, or heert fallure. Liet only one cause on each line. intervei Batween ō IMMEDIATE CAUSE (Final Onset and Death the within 24 cremation, disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) years traumatic event, certificate be executed prior to burial, CERTIFICATION Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF): has been signed by the attending physician Dept. of Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Diseese or injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? 1 TES 2 PLNO OF DEATH? 1 TYES 2 'NO **PHYSICIAN**: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) this certificate h Item HOSPITAL OTHER: 1 TYES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Raeldence 6 ☐ Other (Specily) <u>o</u> 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Natural . DIRECTOR: After the hours after death w 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, atc. (Specify) 62 ETED 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) S Could not be 4 Homicide 28 datermined Item COMPL 1 ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) and menner ee stated. TO THE HOSPITAL OF TO THE FUNERAL DE Be filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and menner se stated. 29d. DATE SIGNED (Month, Glay, Year) 29c. LICENSE NUMBER BE 2 OF DEATH (ITEM 27) (Type, Print) 1995 32 REGISTRAR'S

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BALTIMORE, MARYLAND 21215-0020

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P.O.
SDS,
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VITAL
OF
DIVISION

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1. DECEDENT'S NAME (First, Middle, Last) Darrell	L	1	NELSON		2. DATE OF DEATH MONTH D. NOV 1.		3. TIME OF DEATN		
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.1	BIRTNPLACE (State or Fore		
	212 41 8768	1 💢 M 2 🗆 F	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) DEC . 2.3		Country)		
	9a. FACILITY NAME (If not institution, give :	street and number)			OR LOCATION OF DE		9c. COUNTY	MARYLAND OF DEATH		
СТОВ	UNIVERSITY OF	MARYLAND	HOSP	BAIT	IMORE.					
	RESIDENCE OF DECEDENT						N/	A		
E			10c. CITY	r, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?		
	MARYLAND N 10e. STREET AND NUMBER	/A	B	ALTIMO				1 YES 2 N		
ERAL	A STATE OF THE STA	TTTT		10	f. ZIP CODE		10g. CITIZEN	OF WNAT COUNTRY?		
N.	4986 DENMORE A	VENUE 12. WAS DECEDENT EVER	hitin anima		21215		II.S.	OF A.		
FUN	1 Never Married 2 Merried	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Maxicar		or No— 14.	RACE — American Indian Black, While, atc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR I	DATES	1 TYES	NO Specify			Specify:		
<u> </u>	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KINO OF BUS	SINESS/INDUST	BLACK		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of w life. Do NOT use	vork done during mo e retired.)	ost of working	3311-010-00-00-00-00				
₽ I	NONE		NEVER V	WORKED		NON	IE.			
COMPL	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	IE (First, Middle, Malden				
ш	CLAUDE NELS	ON, SR.			LAURTE	ANN WILS	ON			
0 B	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural R	oute Number, City or Tow		io)		
-	MR. DEAN SYLVI	A	4986	DENMOR	RE AVE.	BALTO.,	MD. 2	1215		
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ram		b. PLACE AND DATE O	F DISPOSITION (No			CATION — City			
	4 Donation 5 Other (Specify)	M'	metery, crematory or oth Γ . $ZION$	CEM. 1	1/21/95	BAT	TIMOR	E MARYLAN		
	21. SIGNATURE OF FUNERAL SERVICE LIC	DENSEE TO THE	. GWYNN		ND ADDRESS OF FAC	ILITY				
	* Lewis -	1. Hurin		LEWIS	T. GWY	NN FUNER	AL HO	ME 21215		
	23. PART i. Enter the diseases, or	1000		ot enter the mo	PARK HE	IGHTS AV	E R	AI.TO MD		
	anock, or neert tellure.	Liet only one course on a	eech line.				, , , , , , , , , , , , , , , , , , , ,	Interval Bet		
- 3	IMMEDIATE CAUSE (Finel disease or condition	NEUROH ASILOMA						6MONT		
	resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF):				OHOMI		
z		RESPIRATORY	FAILURE					3DAYS		
CERTIFICATION	Sequentially list conditions, oue TO (OR AS A CONSEQUENCE OF):									
2	CAUSE (Disease or Injury	C								
Ë	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):						
H	Comming in death, cray	d								
	PART II. Other significant condition	ne contributing to deeth	but not resulting in	n the underlying	g ceuse given in F	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FIND		
EDICAL						PERFOR		AMILABLE PRIOR TO		
0 "								COMPLETION OF CAL		
						1 🗆 YES 2	Æ NO	COMPLETION OF CAL OF DEATH?		
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	DE DEATH YES	S I NO K	LINCERTAIN	_ -	Æ] NO			
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH YES		UNCERTAIN	_ -	₽ ₩0	OF DEATH?		
Σ	The second secon	HOSPITAL:	26. PLACE OF DEATI	H (Check only one) OTHER:			A) NO	OF DEATH?		
Σ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1A inpatient 2 ER/Out 28e. DATE OF INJURY	26. PLACE OF DEATI	OTHER: 4 Nursing Hom	ne 5 - Residenca 8	Other (Specify)		OF DEATH? 1 □ YES 2X NO		
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Neturel 5 Pending	HOSPITAL:	26. PLACE OF DEATI	H (Check only one) OTHER: 4 Nursing Hom OF 28c, INJ	e 5 Residence 8			OF DEATH? 1 □ YES 2X NO		
BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation	HOSPITAL: 1A Inpatient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY	26. PLACE OF DEATI tpatient 3 DOA 28b. TIME INJU Y — At home, farm, st	H (Check only one) OTHER: 4 □ Nursing Hom E OF 28c, INJ IRY WO 1 □ 1	e 5 Residence 8 URY AT PRK? YES 2 NO	Other (Specify) 28d. DESCRIBE NOW II 281. LOCATION (Street a	NJURY OCCURE	OF DEATH? 1 VES 2X NO		
TED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation	HOSPITAL: 1A Inpetient 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year)	26. PLACE OF DEATI tpatient 3 DOA 28b. TIME INJU Y — At home, farm, st	H (Check only one) OTHER: 4 □ Nursing Hom E OF 28c, INJ IRY WO 1 □ 1	e 5 Residence 8 URY AT PRK? YES 2 NO	Other (Specify) 28d. DESCRIBE NOW II	NJURY OCCURE	OF DEATH? 1 VES 2X NO		
TED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATN 1 X Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined	HOSPITAL: 1A Inpatient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spe	26. PLACE OF DEATI tipatient 3 DOA 28b. TIME INJU Y — At home, farm, st ecity)	H (Check only one) OTHER: 4 Nursing Hom OF 28c. INJ OF 1 1	e 5 Residenca 8 URY AT IRK? YES 2 NO	Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Yown, State)	NURY OCCURE	OF DEATH? 1 VES 2X NO		
MPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1X Inpatient 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe	28. PLACE OF DEATI tipatient 3 DOA 28b. TIME INJU Y — At home, farm, st cof(y)	H (Check only one) OTHER: 4 Nursing Hom OF 28c. INJ JRY M 1 V treet, factory, officed	He 5 Residence 8 URY AT VES 2 NO e and place, and due to	Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street as City or Town, State) the cause(a) and man	NJURY OCCURE	OF DEATH? 1 YES 2X NO ED ural Route Number,		
COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1X Inpettent 2 □ ER/Out 28e. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe	28. PLACE OF DEATI tipatient 3 DOA 28b. TIME INJU Y — At home, farm, st cof(y)	H (Check only one) OTHER: 4 Nursing Hom OF 28c. INJ JRY M 1 V treet, factory, officed	Ne 5 Residence 8 URY AT NRX YES 2 NO e and place, and due teeth occured at the t	Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Town, State) the cause(a) and man me, data and placa, en	nd Number or Ri	OF DEATH? 1 YES 2X NO DURAL Route Number, use(a) and manner ea state		
BE COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1X Inpettent 2 □ ER/Out 28e. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe	28. PLACE OF DEATI tipatient 3 DOA 28b. TIME INJU Y — At home, farm, st cof(y)	H (Check only one) OTHER: 4 Nursing Hom OF 28c. INJ JRY M 1 V treet, factory, officed	He 5 Residence 8 URY AT VES 2 NO e and place, and due to	Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Town, State) the cause(a) and man me, data and placa, en	nd Number or Ri	OF DEATH? 1 YES 2X NO ED ural Route Number,		
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O BE COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1X Inpatient 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe ICIAN: To like bast of my know ER: On the basia of axamination	28. PLACE OF DEATI tipatient 3 DOA 28b. TIME INJU Y — At home, farm, st cof(y) wiedge, death occurred on end/or investigation	H (Check only one) OTHER: 4 Nursing Hom OF 28c, INJ JERY M 1 V OTHER: 4 Nursing Hom OF 28c, INJ WO 1 V OTHER: OF 28c, INJ WO 1 V OTHER: OF 100 OTHER: OTH	Ne 5 Residence 8 URY AT VES 2 NO e and place, and due teeth occured at the teeth occured at t	Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Yown, State) the cause(a) and manime, data and placa, end BER	nd Number or Rinner as stated. d dua to the ces 29d. OATE SIG	OF DEATH? 1 VES 2X NO ED Tural Route Number, Use(a) and manner ea state SNEO (Month, Qay, Year)		
O BE COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1X Inpettent 2 = EN/Out 28e. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe ICIAN: To the bast of my know ER: On the basia of axamination	28. PLACE OF DEATI tipatient 3 DOA 28b. TIME INJU Y — At home, farm, st cof(y) wiedge, death occurred on end/or investigation	H (Check only one) OTHER: 4 Nursing Hom OF 28c, INJ JERY M 1 V OTHER: 4 Nursing Hom OF 28c, INJ WO 1 V OTHER: OF 28c, INJ WO 1 V OTHER: OF 100 OTHER: OTH	Ne 5 Residence 8 URY AT VES 2 NO e and place, and due teleth occurred at the teleth occurre	Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Town, State) the cause(a) and man me, data and placa, en	nd Number or Rinner as stated. d dua to the ces 29d. OATE SIG	OF DEATH? 1 VES 2X NO ED Tural Route Number, Use(a) and manner ea state SNEO (Month, Qay, Year)		

particular of which the

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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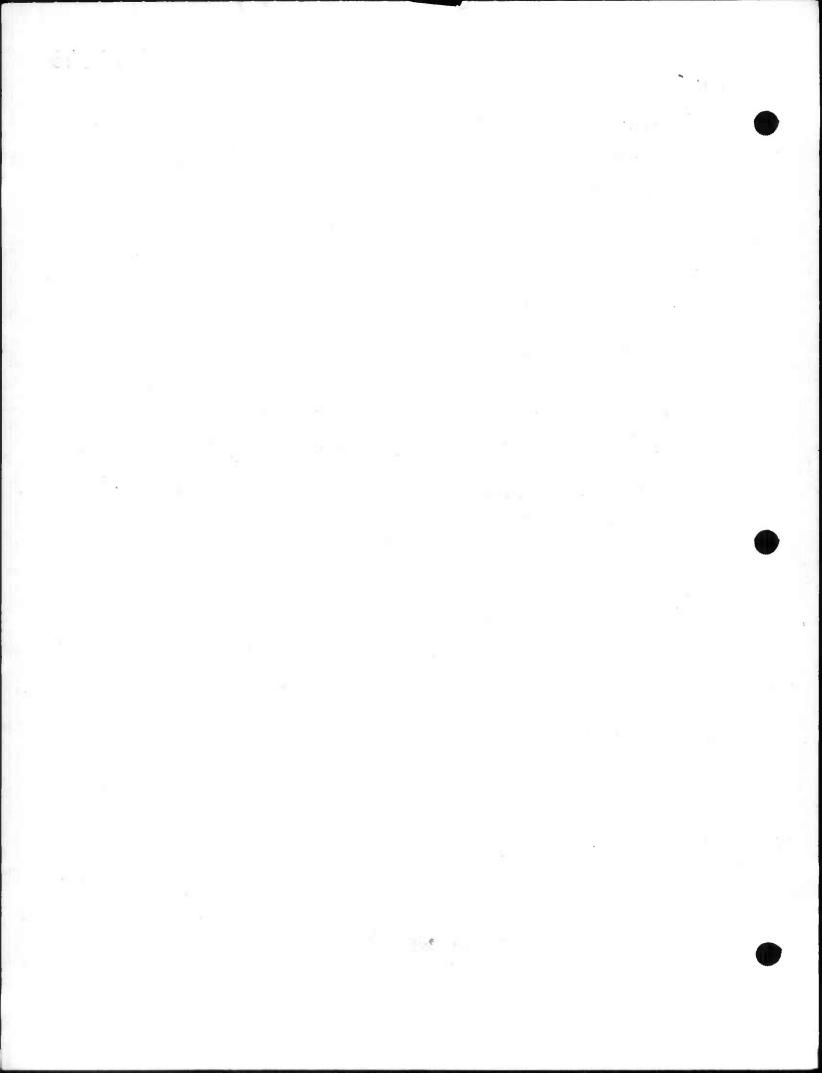
Jacobs-

31. DATE FILED (Month, Day, Year)

34649 Item31 See Item32 11-16-95 Per F/R 95 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Thomas 995 0819 STOVIT 11 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 7. DATE OF BIRTH 213-20-0473 08-04-1925 1 X M 2 1 70 DAYS HOURS MARYLAND YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SINAI HOSPITAL BALTIMORE N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL **PASADENA** 1 YES 2 XNO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8544 SKIPJACK PLACE 21122 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYPES 2 NO IF YES GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ΒY 3 X Widowed 4 Divorced Specify: WHITE COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sn College (1-4 or 5+)
N/A PRINTER BALTIMORE SUN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANK OSTOVITZ LOUISE (UNKNOWN) BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARTIN L. OSTOVITZ 515 WINDHAM COURT, SEVERNA PARK, MD. 21146 20a, METHOD OF DISPOSITION
1 ◯ Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION - City or Town, State LORRAINE PARK CEMETERY Donation 5 - Other (Specify) _ BALTIMORE, MARYLAND 1995 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE SECOND AVENUE, S.W., GLEN BURNIE, MD.21061 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart fellure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition of the -ancer resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate 17 cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART II. Other algolificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY dependent diabetes mel 1 YES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27, MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident M 1 YES 2 NO BY 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide datermined 29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(a) and manner as stated. (Check only one) MEDICAL EXAMINER: On the ition and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(s) and menner as stated. TO THE HOSPIT TO THE FUNER, be filed within 7 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month Day, Year) JHH N157

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bat Talia Davelson Randall NOV 1



YEAR

3. TIME OF DEATN

DHMH-16 Rev 1/89

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

90	with
6876	executed
\tilde{c}	20
L RECORDS, P.O. BOX 68760	certificate
S, P	death
Ö	the
OR	that
REC(requires
	MB
TAL	The
OF VI	S PHYSICIAN: The
DIVISION OF VIT	ATTENDING
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_	HOSPITAL
	TO THE HO
	2
1	1

		FRANK	JOSEF	PH	ORLOS	KY S	TR.				Nove	mber	15,	1995	8:40 A. M
		4. SOCIAL SECURITY NUMI 200-26-8828	BER	5. SEX	6. AGE (In y)	rs. lest birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Month	DE BIRTH	1934		ACE (State or Foreign
3 should	JR.	9a. FACILITY NAME (# not h						OWSC		ON OF DE				INTY OF DEA BALT	
1, 2,	S	RESIDENCE OF DE	10b. COUNT			40015									
. Pages	DIRECTOR	MARYLAND		, NNE ARUNI	DEL	10c, C11	Y, IOWN	1 1000						Od. INSIDE CITY LIMITS? YES 2 1 NO	
permit		10e. STREET AND NUMBER						101.	ZIP COD				10g. CIT	IZEN OF WH	AT COUNTRY?
ansit	FUNERAL	505 DARLENE	AVENUI					21090 U.S.A.							
use as the burial-transit permit. Pages 1, 2, 3 should	ВХ	11. MARITAL STATUS 1 Never Married 2 3 3 Widowed 4 Div	7	12. WAS DECEOE FORCES? IF YES, GIVE 1953-19	1 X YES	2 NO	NO If yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc.								
rse as	E		EDENT'S EDU ly highest grade		16	Give kind of	work done			ng	16b.	KIND OF BU	JSINESS/IN	DUSTRY	
ed for t	PLET	Elementary/Secondary (0-t2)	College (1-4 or 5	+)	MACHII					W	ESTIN	GHOUS	SE	
be detach at once.	E COMPL	17. FATHER'S NAME (First, A FRANK JO	Aiddle, Last)	ORLO	OSKY,	SR.				NER'S NAI		Aiddle, Maide ROSE		MARGIA	WICZ
e 5 should notified	TO B	190. INFORMANT'S NAME (MERLE JUNE		196. MAILING 505 D									21090		
ector, page must be		20a METHOD OF DISPOSITION 1 A Burlet 2 Crematit		ACEAND DATE					11077	00 TE 0 20c. LOCATION — City or Town, State CROWNSVILLE, MD.					
funeral dire		21. SIGNATURE OF EUNER	AL SERVICE LI	CENSEE	1		22.	NAME AN	ID ADORE		CILITYS]	NGLET			HOME,
the fun val.	- 8	195	Den	Atra	skin										E,MD.21061
and completely filled in by the funeral director, page 5 should be detached for burial, cremation, or removal. atic event, the medical examiner must be notified at once.	NO	ehock, or I	resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
ending physician a Hygiene prior to or other traum	CERTIFICATION	fi any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.													
signed by the Health and Me ws any Injur	MEDICAL C	PART II. Other eignificent conditions contributing to death but not resulting in the						nderiyin	g ceuse	PERFORMED? 1 YES 2 NO COMPLETI OF DEATH			WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
as been Dept. of 23 sho		DID TOBACCO (JSE CONT	RIBUTE TO CA	AUSE OF	DEATH Y	ES 🗆	NO [UNC	CERTAIN	NIZ				
State D	SICIAN	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:		PLACE OF DE	OTHE	R:			6X Othe		Чос	pice	
the the		27. MANNER OF DEATH		1 Inpetient 2		26b. Til		26c. INJ	URY AT	asidence		CRIBE HOW		-	
After this death wit marke	D BY P	2 Accident	Pending Investigation Could not be	28e. PLACE	OF INJURY —	At home, farm,	М	1 🗆 '	PRK? YES 2 [□ NO		ATION (Street		er or Rural Ro	ute Number,
LECTOR: rs after rn 28 is	ETEC	4 Homicide	determined	bunding	g, etc. (Specify)						City	or lown, Stat	θ/		
2 N =	COMPLI	CONSCR ONLY		ER: On the best of											and manner as stated.
TO THE FUNERA De filed within 7 IMPORTANT: 1	TO BE (29b. SIGNATURE AND TITL 29b. SIGNATURE AND TITL 30. NAME AND ADDRESS	ll (2 Far	Ulu USE OF OEATI	H (ITEM 27) (Tyo	e. Print)		29c. LIC	DS.	MBER 4-2	>	29d. DA	TE SIGNED	Month, Day, Year)
		DR. KENDA	ALL FA	AULKNER		0 DUL		Y VA	LLE	Y RI	D.,	TOWS	ON,	MD	21204
		31. OATS SILEO (Month, Day)	995	32. REGISTE	RAR'S SIGNAT	URE									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writhin 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit		ce.
retained by the	5 should be det		notified at on
h. Page 6 may be	eral director, page		IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
hours after deat	ed in by the fun	or removal.	medical exan
ecuted within 24	nd completely fill	burial, cremation,	stic event, the
certificate be ex	iding physician a	Hygiene prior to	r other trauma
s that the death	ned by the atter	afth and Mental	any injury, o
The law require	ate has been sig	tate Dept. of He	tem 23 shows
NG PHYSICIAN	fter this certific	ath with the S	marked, or i
AL DR ATTENDI	L DIRECTOR: AN	2 hours after de	t item 28 is
TO THE HOSPITA	TO THE FUNERA	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: II

31. DATE FILED (Month, Day, Your)
NOV1 6 1965

32. REGISTRAR'S SIGNATURE

	азр									95	3	4651	
	FOR STATE REGISTRAR	STATE OF I				T OF H			MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)	Α.	P	ALMI	ER				2. DATE OF DEATH NOV 03	199		TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX 1 1 M 2 F	6. AGE (In yrs. las	t birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. OATE OF BIRTH (Month, Day, Year)		B. BIRTHPL Country)	ACE (State or Foreign	
	9e. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY	r, TOWN O	R LOCATE	ON OF OE	АТН	9c. COUN	TY OF DEA	тн	
08	5111 GOODNOW	RD	D BALTIMORE						CITY				
[2]	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	r		10c. CIT	Y, TOWN	OR LOCATI	ION					Dd. INSIDE CITY	
DIRECTOR	Maryland	Bal				ore				LIMITS?			
	10e. STREET AND NUMBER					10f.	ZIP CODI	E		10g. CITIZ	EN OF WH	AT COUNTRY?	
E	5111 Goodnow Road	d-#A					2	1206			U.S.A		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES?	IT EVER IN U.S. AR I YES 2 N			WAS DECI If yes, spe 1 TES	city Cube	n, Mexicai	IIC ORIGIN? (Specify Yes n, Puerlo Rican, etc.)	or No-	14. RACE — Black, V Specify:	American Indian, Valte etc. Black	
	15. DECEDENT'S EDU	CATION				CCUPATIO			16b. KIND OF BU	SINESS/INDU	ISTRY		
COMPLETED	(Specify only highest grade	College (1-4 or 5	life	ive kind of Do NOT u	work done se retired.)	during mos	st of workin	ng					
BE CON	17. FATHER'S NAME (First, Middle, Last)		•				18. MOTI	HER'S NA	ME (First, Middle, Maiden	Sumeme)			
TO B	19e. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRES	S (Street ar	nd Number	or Rural F	Route Number, City or Tow	n, State, Zip (Code)		
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 4 Donetion 5 (2) Other (Specify) IN State							, State					
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE Rona	ld Wade,	Dir					Board-655 more, Mary			re, Street	
	23 PART I. Enter the diseases, or ehock, or heert feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. A. Te	use on each line	te	not enter							Approximate interval Between Onset and Death	
N	Sequentially list conditions,	b	OR AS A CONSE										
ERTIFICATION	if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	C	OR AS A CONSEC										
	thet initieted events resulting in death) LAST	d	OR AS A CONSE	DUENCE O	F):								
LC	PART ii. Other eignificent condition	s contributing to	deeth but not r	recuiting	in the u	nderiying	ceuee	given in			24b. W	ERE AUTOPSY FINDINGS	
MEDICAL									PERFOR	MED?	C	WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
	DID TOBACCO USE CONT	RIBUTE TO CA	AUSE OF DEA	TH Y	ES 🗆	NO [l unc	ERTAI	NO Lisa	ut.	1	☐ YES 2 ☐ NO	
₹ 	25. WAS CASE REFERRED TO MEDICAL			E OF DEA						, and			
Sic	EXAMINER? 1 X YES 2 □ NO	HOSPITAL:	☐ ER/Outpatient 3	□ DOA	OTHE 4 Nu	R: rsing Hom	• 5X1 R	eldence	6 Other (Specify)				
	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 28d. DESCRIBE HOW INJURY OCCURED												
FED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE building	OF INJURY — At he , etc. (Specify)	ome, ferm,	street, fac	ctory, affice	•		28f. LOCATION (Street City or Town, State)		or Rurel Rou	ite Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS								to the cause(e) end me			and menner ee steted.	
BE	29b. SIGNATURE AND TITLE OF GERTIFIE	R U.	Kul	10			29c. LIC	C . M	MBER • E	NOV	SIGNED (A	1995°	
	30. NAME AND ADDRESS OF PERSON WA	O COMPLETED CA	ISE OF THATH (ITE	METO (Bury	Print)								

DHMH-16 Rev 1/89

who completed chase of the Arth (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITATO TO THE FUNERA DE filed within 72 IMPORTANT. II

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29b. SIGNATURE AND TITLE OF CERTIFIER

DENNIS CHUTE ND

31. DATE FILED (Month, Day, Year)

Dennish.

Chute mo

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

uned by the hospital of attending physician,	r, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should		fled at once.
leath. rage o may be retail	funeral director, page 5 sho		xaminer must be notif
WITHIN 24 HOURS AFTER O	mpletely filled in by the	cremation, or removal.	went, the medical e
in certincate be executed	ttending physician and co	Il Hygiene prior to burial	ws any injury, or other traumatic event, t
law requires that the dea	s been signed by the a	lept. of Health and Menta	arked, or item 23 shows any injury,
OR ALLENDING PHYSICIAN: The Jaw	: After this certificate ha	within 72 hours after death with the State C	is marked, or item
HOSPITAL DR ALTER	FUNERAL DIRECTOR: After	within 72 hours after	RTANT: If Item 28 is marked, or if

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR P M RUSSELL PLITT NOV 1995 1315 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 52 Feb. 1997 1943 1 X M 2 - F 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1224 SOUTH CAREY STREET DIRECTOR BALTIMORE CITY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY Maryland Baltimore 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 21230 1224 S. Carey Street 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. Specify: White FORCES? 1 YES 2 1 Never Married 2 Married ΒY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S FOUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi (Give kind of work done life, Do NOT use retired.) Elamentary/Secondary (0-12) Collega (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 1 Burlai 2 Cremation 3 Ram
4 Donation 5 XOther (Specify) ioval from State EL SIGNATURE OF FUMERAL SERVICE LICENSEE ROnald Wade, Dir. 32 NAME AND ADDRESS OF FACILITY BOArd-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 Janun Laur 22 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. Liet only one cause on each line. intervai Batween Onset and Death MMEDIATE CAUSE (Finel disease or condition **HEMOPTYSIS** recuiting in death) DUE TO (OR AS A CONSEQUENCE OF): INVASIVE BRONCHOGENIC CARCINOMA CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AWAILABLE PRIOR TO CHRONIC OBSTRUCTIVE PULMONARY DISEASE COMPLETION OF CAUSE t XYES 2 NO OF DEATH? 1 XYES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☑ NO ☐ UNCERTAIN ☐ PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 \(\text{Nursing Home } \(\text{X} \text{Raaldence } \) 8 \(\text{Other (Specify)} \) HOSPITAL XXYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28b. TIME OF INJURY 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending t YES 2 NO ВУ Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 8 Could not be 4 Homicide 29a. CERTIFIER
(Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMPL

32. REGISTRAP'S SIGNATURE

29c. LICENSE NUMBER

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29d. DATE SIGNED (Month, Day, Year)

NOV. 6,1995

7. . 3

BALTIMORE, MARYLAND 21215-0020 P.O. BOX 6876

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed

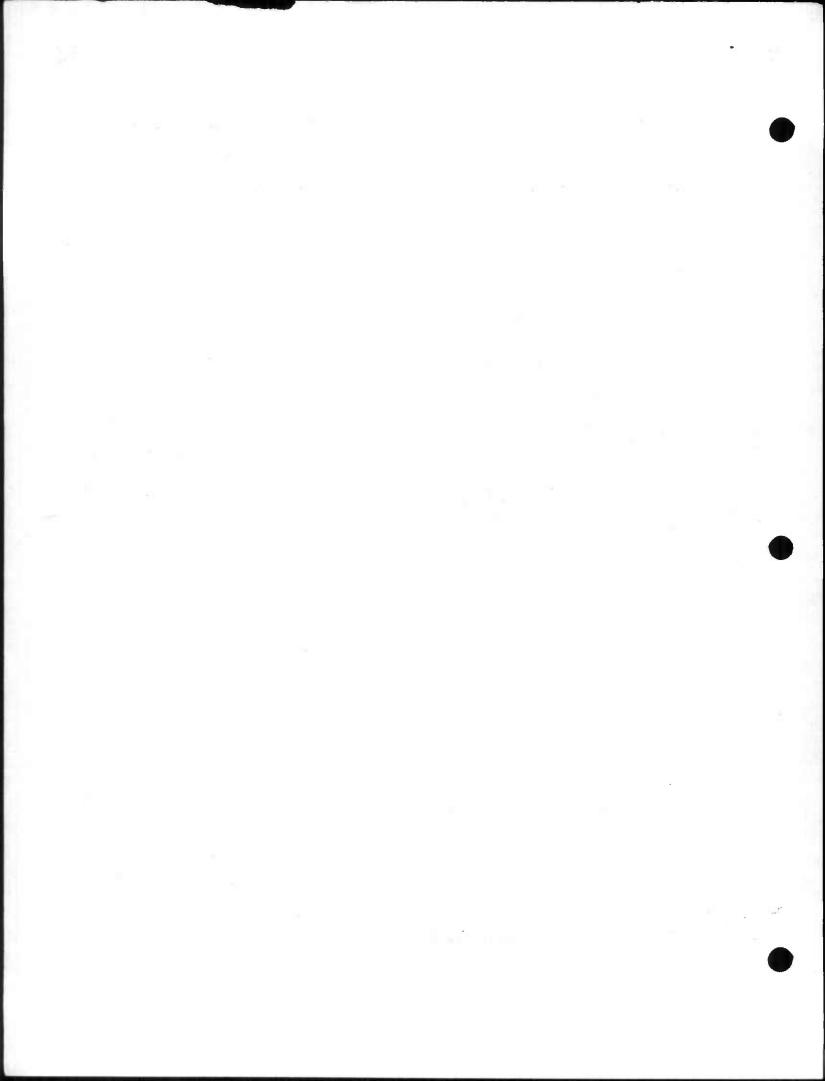
DIVISION OF VITAL RECORDS.

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATN NOVEMBER 10, 1995 4:30 R. PHILLIES BERTHA 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS MIN. 1 M 2 X F 92 Maryland Unknown 216-07-8297 funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATN DIRECTOR 1110 E.36th STREET BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore, City Maryland N/A 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 1110 E. 36th. Street II.S.A 21218 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 X Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, atc.)
1 ☐ YES 2 ☑ NO Specify: IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Insurance Co. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) Charles Phillips notified at Unknown Unknown 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) Mrs. Evelyn Nolte Chapelwood Court , Timonium , Maryland pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20e, METHOD OF DISPOSITION
1 X Buriel 2 Cremetion 3 Removal from State 20c. LOCATION — City or Town, State OATE must St. Matthews Cemetery 11/16/95 Baltimore, Maryland Donation 5 C Other (Specify) examiner ²². NAME AND ADDRESS OF FACILITY Leonard Home, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICEN 66 Jehrefer 5305 Harford Road Baltimore , Maryland 21214 medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate interval Between ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Deeth the diseese or condition Alherosclerohiz lardiavascular disease reculting in death) event. OUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL shows any Femur COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) EXAMINER? HOSPITAL: OTHER: 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home KResidence 6 Other (Specify) the of 28e. DATE OF INJURY (Month, Day, Yeer) DIRECTOR: After this cent hours after death with the litem 28 is marked, o 27. MANNER OF DEATH 28c. tNJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 16 30 11-10-95 м 1 YES 2 NO our BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, lectory, office building, etc. (Specify) 281. LOCATION (Street and Nur. 3 Sulcide 6 Could not be COMPLETED 4 Homicide FUNERAL (-2 MEDICAL EXAMINER: On the beets of examination end/or investigation, in my opinion, death occured at the time, date and piece, end due to the cause(e) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE NOVEMBER 11,1995 O.C.M.E. 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) rouler 111 Penn Street, Baltimore, Maryland 21201 32. EGISTRAR'S SUNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

hours after death. Page 6 may be retained by the hospital or attending physician. the attending physician and completely filled in by the it Mental Hygiene prior to burial, cremation, or removal. has been signed by t Dept. of Health and this certificate h with the State [

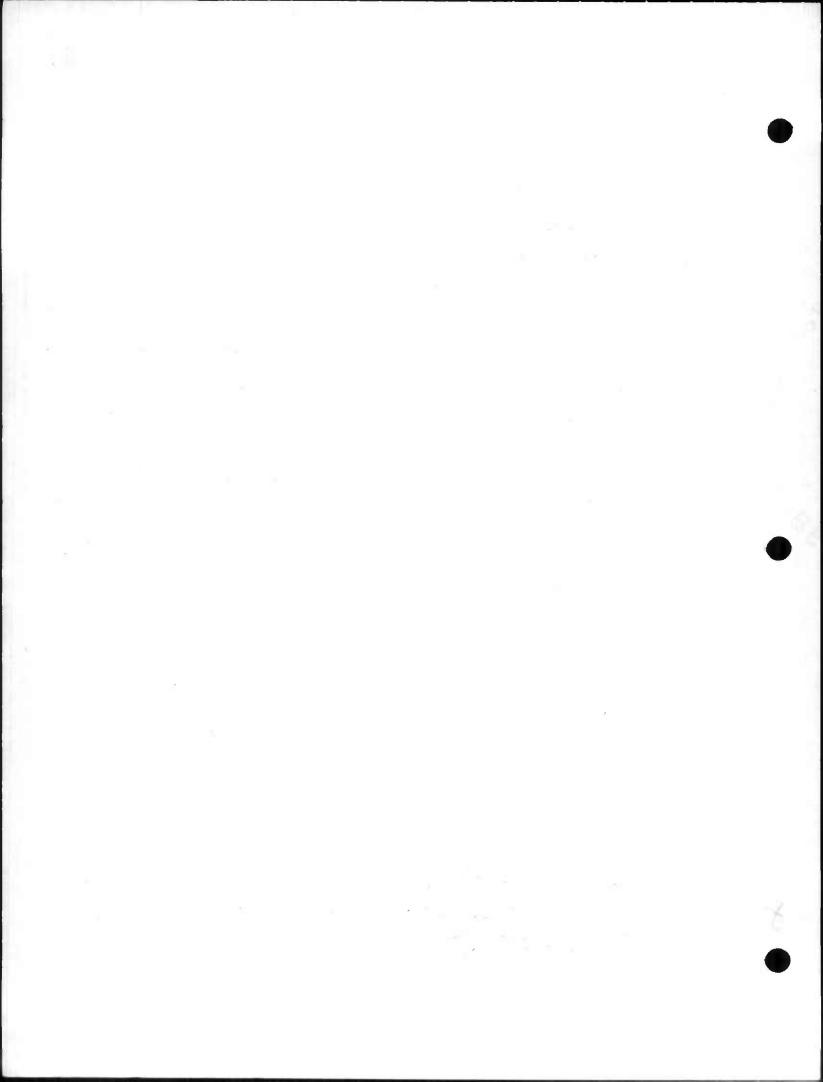
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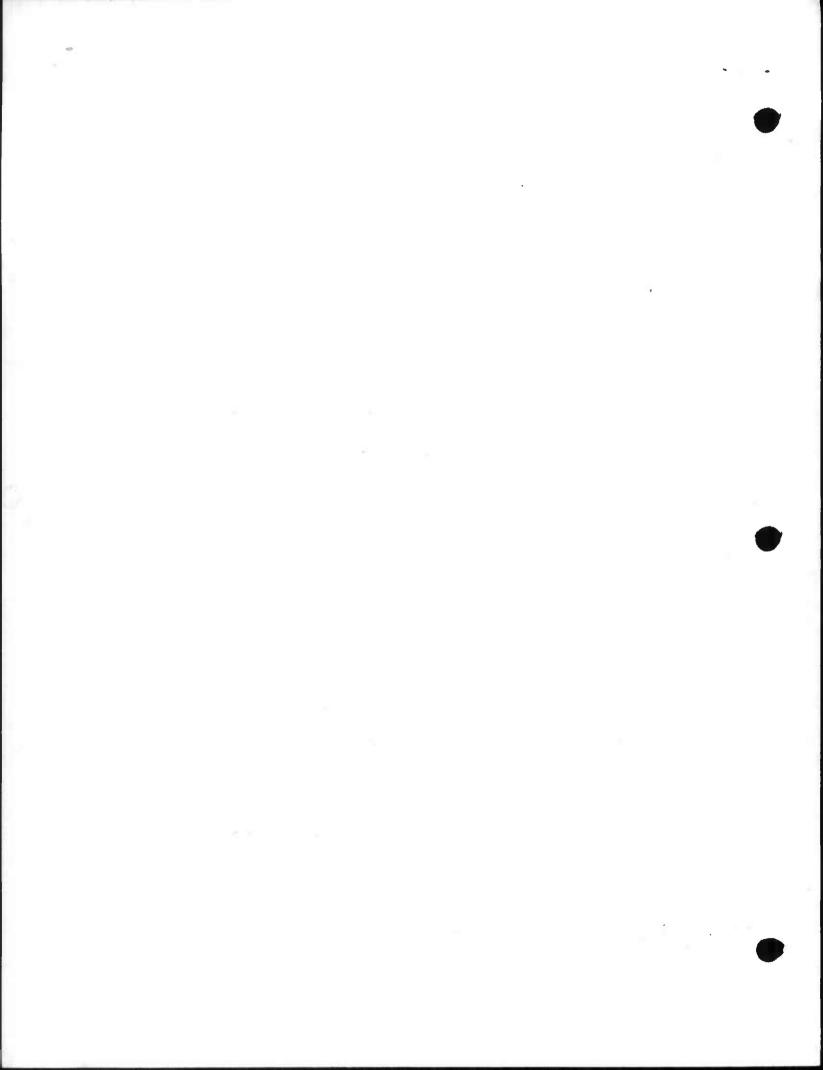
FOR

BALLIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68/6	e executed	an and cor	umatic e
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/IIA	IN: The Is	ficate has State De	Item 2
7	PHYSICIA	this certi	rked, or
SICE	ENDING	TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with	8 is ma
2	L OR ATT	DIRECTI hours at	item 2
	HOSPITA	FUNERAL Within 72	TANT: If
	TO THE	TO THE De filed v	IMPORT

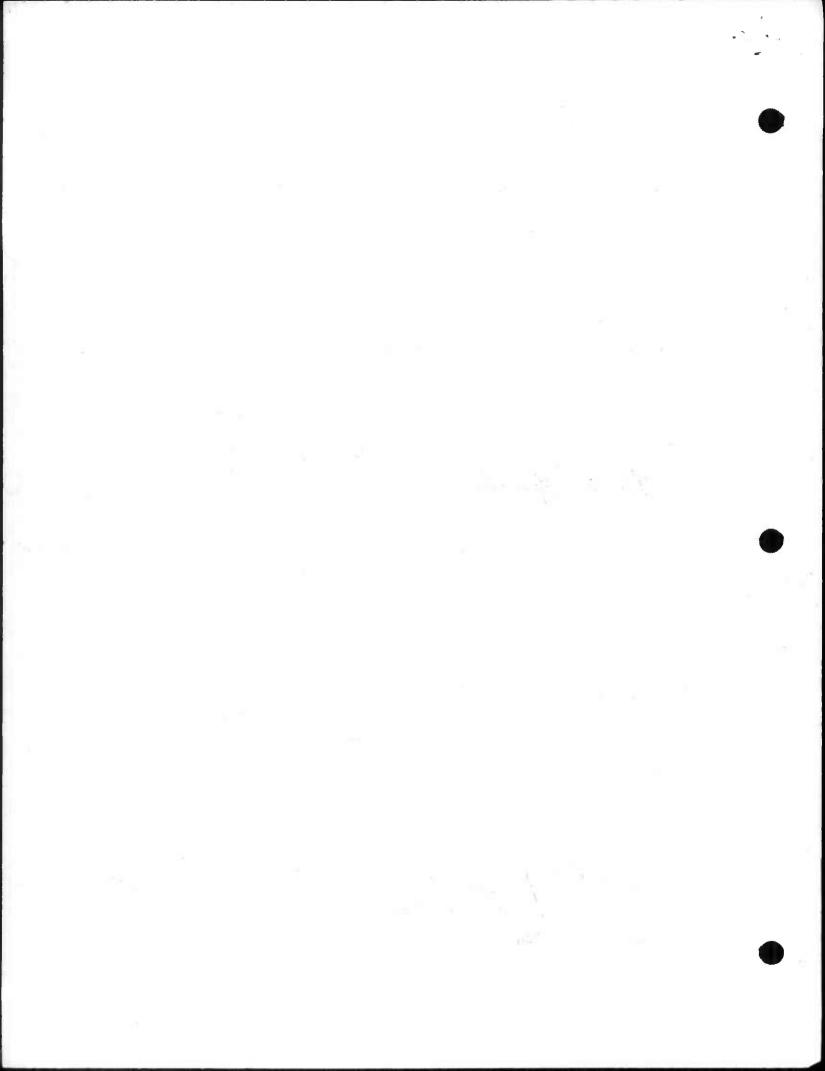
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTME CERTIFICA			MENTAL HYGIEN	E	
		ele, Last) E. PORTER				2. DATE OF DEATH DATE OF DAT		
	4. SOCIAL SECURITY NUMBER 212-16-3613	1 □ M 2 🕅 F 88		7. DATE OF BIRTH (Month, Day, Year) 2 / 23 /	190750	OUTH CAROLINA		
TOR	98. FACILITY NAME (If not institute (HOME) 1724 C	OLLINGTON AVENUE	ATH	BALTIMORE				
DIRECTOR	10a. STATE 10b.	COUNTY BALTIMORE	N .		10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	1724 COLLINGT	21213			S.A.			
B	11. MARITAL STATUS 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	₹ ₩0		Ify Cuban, Maxicar	IC ORIGIN? (Specify Yea n, Puerto Rican, stc.)		NACE — American Indian, Black, White, etc. Specify: BLACK
COMPLETED		AT'S EDUCATION nest grade completed) College (1-4 or 5 +)	18a. DECEDENT'S USUA (Give kind of work de life. Do NOT use retire MA	one during most		166. KIND OF BUS		REAM COMPANY
BE COM	17. FATHER'S NAME (First, Middle, WILBUR GILL G					ME (First, Middle, Malden SETH MCMILL		
10 B	190. INFORMANT'S NAME (Type/PI MILDRED BRI		196. MAILING ADOF	LINGTON	Number or Rural R N AVENUE	DOUGH Number, City or Tow. BALTIMORE	n, State, Zip Code , MARYL	ÄND 21213
	20a METHOD OF DISPOSITION 1A Burlel 2 Cremation 3 4 Donation 5 Other (Spec	cify)DR	PLACEAND DATE OF DIS netery, cremetory or other pla UID_RIDGE	CEMETER	RY 11/1	3/95 PIKE	CATION — City of	MARYLAND
	21. SIGNATURE OF PUNERAL SET	Mal Del		ESTEP E		FUNERAL H		YLAND 21217
CATION	ahock, or haart IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A			, .			Approximate Interval Between Onset and Death Car
CERTIFICATION	CAUSE (Disease or Injury that initiated evanta resulting in death) LAST	d	CONSEQUENCE OF):					
PHYSICIAN: MEDICAL		onditions contributing to death b				PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN:	DID TOBACCO USE 25. WAS CASE REFERRED TO ME EXAMINER?	CONTRIBUTE TO CAUSE C	28. PLACE OF OEATN (Ch		UNCERTAIN	<u> </u>		
HYSI	1 TYES 2 NO 27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outs 28a. DATE OF INJURY (Month, Day, Year)	patient 3 DOA 4 D	Nursing Nome 28c. INJUI	RY AT	6 Other (Specify) 28d. DESCRIBE NOW I	NJURY OCCURE	D
D BY P	1 Naturel 5 Pend 2 Accident Inves 3 Suicids 8 Coult	fing stigstion 28e. PLACE OF INJURY	/ — At home, farm, street,	M 1 YE		28f. LOCATION (Street	and Number or Re	rei Route Number,
COMPLETE	29a. CERTIFIER	ng PNYSICIAN: To the best of my know		the Alma deta o	-4 51000 0004 400	City or Town, State)		
OMP	one)	EXAMINER: On the basis of examination						ree(a) and manner as stated.
8	296. SIGNATURE AND TITLE OF	Unlewood	IM.D.		29c. LICENSE NUN			mber 10, 1995
유	30. NAME AND ADDRESS OF PER	IES A. UNDERW	OOD, M.D		NS HOPK	INS HOSPIT	ML, BA	LTIMOEE, MD
	31. DNEUV 1 6 1995	July 32 hegistran's	A CALL				•	



	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEI	PARTMENT FIFICATE	OF H	IEALTH AND	MENTAI				
	1. DECEDENT'S NAME (Fine, Middle, Last)	ice Ro	TAN)			MONTH	OF DEATH			TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 578-34-3175			MONTHR	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTN	8	. BIRTNPL.	ACE (State or Foreign
TOR	Lorien Nursing Ho						EATN			_	TN .
DIREC		1									od. INSIDE CITY LIMITS? YES 2 NO
VERAL		NW			101	20011					T COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 TYES	2 X NO		f yee, sp	ecify Cuben, Mexic	en, Puerto F	? (Specify Yas Rican, etc.)	or No — 1	Black, W.	American Indian, white, atc. Black
LETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind	id of work done in idea (idea)	CCUPATIO	ON st of working				STRY	
	17. FATNER'S NAME (First, Middle, Last) UNKNOWN	NOTIE	HOMEM	dver			AME (First, A			5 1104	
TO BE	19a. INFORMANT'S NAME (Type/Print) James Rotan, Jr.	(Son)				nd Number or Rural	Route Numb				
	20+. METNOD OF DISPOSITION	20b.	PLACE AND D	ATE OF DISPOS	ITION /Ne	me of No	V DATE	20c. LO	CATION — CI		
		CENSEE	~	22. Le:	NAME AN	M & Russ Win Kno.	ACILITY Sell (C Witz	ke Fu	neral , MD	L Home 21045
	23. PART i. Enter the diseases, or o	complications that caused Liet only one ceuse on es	sch line.	Do not enter	the mo	de of dying, suc	ch es cerd	llec or respi	ratory srres	it,	Approximete interval Between
1 1	Sequentially list conditions, if any, leeding to immediate	b. Hyperter DUE TO (OR AS A	CONSEQUENCE CONSEQUENCE	CE OF):	enio	sclevet	ric W	lant	dis	ease	years.
RTIFIC	cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in desth) LAST	OUE TO (OR AS A	CONSEQUENC	CE OF):							
AL.	PART II. Other significent condition	s contributing to deeth be	ut not result	ing in the un	derlying	g ceuse given in	Part i.	PERFOR	MED?	AW	ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE
Σ	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH	YES 🗆 1	10 X	UNCERTAI	N 🗆	1 NES 2	NO	DF	DEATH? YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OFHER	t:						
PHY	27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)			28c. INJ	URY AT RK?	_		NJURY OCCU	RED	
ΕĐ	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, fe	erm, street, fect	ory, office				and Number or	Rural Route	e Number,
MPL											d menner ee stated.
	Rechard llo	Culule	26	(7		D31.	575		11	-/	3-95
	SI. DATE FILEO (MONTH) PROMPT (1.	TZ 950	1 0	COL 1	Ans	rapolis	Ra	1 81	Hut	Cit	EMD SIONS
	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIR	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 578-34-3175 9e. FACILITY NAME (If not Institution, give s LOTION NUTSING Ho RESIDENCE OF DECEDENT 10e. STATE 10e. COUNTY 10e. STATE 10e. STATE 10e. COUNTY 10e.	1. DECEDENT'S NAME (Pay, Micdie, Last) 4. SOCIAL SECURITY NUMBER 578-34-3175 9. FACILITY NAME (If not institution, give street and number) LOTIEN NUTSING HOME 10. STATE 10. COUNTY N/A 10. STATE 10. COUNTY N/A 10. STATE 10. COUNTY N/A 11. MANITAL STATUS 1 Never Merried 2 Merried 3 Widowed 1 Diverced 15. DECEDENT'S EDUCATION FORCES? 1 YES, GIVE WAR OR D. 17. FATNER'S NAME (First, Micdie, Last) Unknown 19. INFORMANT'S NAME (Pay-Print) James Rotan, Jr. (Son) 20. METNOD of DISPOSITION 10. STATURE OF PURERAL SERVICE LICENSEE LACL JAMES AND COMPLETE SERVICE LICENSEE LACL JAMES (Finel diseases, or complicitions that caused shock, or heart feiture. Liet only one cause one individual sease or condition. 18. SEQUENTIALLY IS SEQUENTIALLY SEQUENTIAL	1. DECEDENT'S MAME (First, Middin, Last) 1. DECEDENT'S MAME (First, Middin, Last) 1. DECEDENT'S MAME (First, Middin, Last) 1. DECEDENT'S EDUCATION 1. DECEDENT'S EDUCAT	STATE GOVERNMENT WAS CONTRIBUTE TO CAUSE OF DEATH YES STATE STATE CAUSE (In yrs. last bornday) F LINCES STATE STATE State (In yrs. last bornday) F LINCES STATE State (In yrs. last bornday) F LINCES STATE State (In yrs. last bornday) State (In yrs. last bo	1. STATE 1. DECEDENT'S NAME (1795) Microle, Lasty 1. DECEDENT (1795) Microle, Lasty 1. DECEDENT (1795) Microle,	THEOLOGRAPH 1. DECEDENT'S NAME (PTS) Micros, Last) 1. DECEDENT'S NAME (PTS) Micros, Last) 2. STATE OF MICROS SCIENT NUMBER 3. SOCIAL SECURITY NUMBER 5. SEX S. AGE (in yes, last bid bid help) 2. STATE (In yes, last bid help) 3. STATE (In yes, last bid help) 4. SOCIAL SECURITY NUMBER (In constitution, pice stress and muster) 3. STATE (In yes, last bid help) 4. SOCIAL SECURITY NUMBER (In constitution, pice stress and muster) 4. SOCIAL SECURITY NUMBER (In constitution, pice stress and muster) 5. STATE (In yes, last bid help) 5. SECURITY NUMBER (In constitution), pice stress and muster) 1. Columbia (In yes) 1. STATE (In	The STATE ST	1. STATE 1. DECEMBETS HAME Play Mode, Lasy 1. DECEMBETS HAME Play Mode, La	TO STATE OF MANUAL PROPERTY SAME PROJ. MODIL. Land DECEMBER 9 AND ALGO ALGO ALGO ALGO ALGO ALGO ALGO ALGO	STATE OF MARKET BY MADE 1799 MADE



		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle 18st)					2. DATE OF DEATH MONTH D	31 199	S. TIME OF DE	ATH PA
pir		4. SOCIAL/SECURITY NUMBER 213-66-9918	1 □ M X X F 82,	n yrs. last birthday) YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Jan. 24,19	13	BIRTHPLACE (State or Country) Maryland	Foreign
, 2, 3 should	стов	90. FACILITY NAME (If not institution, give str Johns Hopkins - Bi RESIDENCE OF DECEDENT				cimore C		Balti	of DEATH imore City	У
permit. Pages 1,	DIREC	10e, STATE 10b, COUNTY	timore	10c. CIT	Y, TOWN OR LOCA Balt	imore Co	ounty		10d, INSIDE CI LIMITS? 1 YES 2	
155	FUNERAL	100. STREET AND NUMBER 4854 Hazelwood Ave	nue		10	1. ZIP CODE 212	206	10g. CITIZEN	OF WHAT COUNTRY	
TLAND 21213-0020 by the hospital or attending physician. be detached for use as the burial-transit at once.	ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2X NO	If yea, sp	ENDENT OF HISPA ecity Cuben, Mexic XX NO Speci	NIC ORIGIN? (Specify Yes an, Puerlo Ricen, etc.) by:		RACE — American in Black, White, atc. Specify: White	idlen,
V Z1Z15 Vital or attend d for use as	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 9th grade	ATION completed) College (1-4 or 5+)	16e. OECEDENT'S (Give kind of v life. Do NOT us		ON ost of working	166. KIND OF BUILD			
MAK TLAND retained by the hospit 5 should be detached outflied at once.	E COMPL	17. FATHER'S NAME (First, Middle, Lest) George Reiss	N/ A	поозе		18. MOTHER'S NA	AME (First, Middle, Malden		•	
MAK retained 5 should	TO BE	190. INFORMANT'S NAME (Type/Print) Vernon Reinhardt		19b. MAILING 4854	ADDRESS (Street of Hazelwo		Baltimore,	n, State Zip Coc Md . 2	1206	
death. Page 6 may be tuneral director, page		20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remor	val from State ceme	PLACE AND DATE OF THE PLACE AND DATE OF THE	rk Cemet	ery ll-	3-95 Balt	imore,		
ter death. the funera	Ц	21. SIGNATURE OF FUNERAL SERVICE LICE	esseln		Las 740	l Belair	eral Home Rd. Balti	more,	Md. 21236	
within 24 hours at pletely filled in by cremation, or rement, the medic		23. PART I. Enter the diseases, or co ahock, or heart failure. L IMMEDIATE CAUSE (Final disease or condition resulting in death)	proplications that caused list only one cause on as DUE TO (OR AS A C	ch lina.		da of dying, aud	th as cardiac or respi	ratory arrest,	Interval Onset a	mata Between nd Death
th certificate be ending physician I Hygiene prior to	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa reaulting in death) LAST	OUE TO (OR AS A C							
v requires that been signed by t. of Health and shows any	AN: MEDICAL	PART II. Other algorificant conditional CIFF Cud I par sen si ch - DID TOBACCO USE CONTR	stage der	mentia	1 14	-/0 W	PERFOR	MED?	24b. WERE AUTOPSY AMAILABLE PRIO COMPLETION DF OF DEATH? 1 YES 2	F CAUSE
e ate	SICI		HOSP/TAL:	6. PLACE OF OEAT	ОТНЕМ:		5 ☐ Other (Specify)			
The this	ву рну	27. MANNER OF OEATH Value 5 Pending 2 Accident Investigation	26e. OATE OF INJURY (Month, Day, Year)	26b. TIMI	M 1 1	RK? /ES 2 NO	26d. DESCRIBE HOW II	NJURY OCCURE	ED	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 6 Could not be 4 Homicide Stermined	26e. PLACE OF INJURY – building, atc. (Specif)	ν)			26f. LOCATION (Street e City or Town, State)		lural Route Number,	
425	COMPL	one) 2 MEDICAL EXAMINER.	AN: To the best of my knowled On the basis of examination						use(s) end manner ee	stated.
TO THE HOSPI TO THE FUNEF be filed within	TO BE	29h. BIGNATURE AND TITLE OF CRITIFIED 30. HAME AND ADDRESS OF PERSON WHO	COMPLETED PAUSE OF DEAT	nD		DO/	85	294. DATE 910	13/195	9)
1		31. DATE FILED (Month, Day, Year)	- 15UR	TURE 27) (Vpe,	530	5 Hay	LINS BO	GUIZN	CR 217	224
4		-70-NOV161	32, REGISTRAR'S, SIGNAT	under Ran	Call		•			



	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
Sician.	al-transit		
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6 may be retained by the hospital or atte	etach		
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eam certificate de executed within 24 hours after death. Page 6	neral		
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						95 3	4657	
_	1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTMENT OF CERTIFICATE OF	HEALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) CHARLES	W	SNEERII	ICED	2. DATE OF DEATH	3 19 5 5	3. TIME OF DEA	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In y	rs. lest birthday) IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		NPLACE (State or	
	246-38-6273	1★ M 2 □ F 77	YRS. MONTHS DAYS	HOURS MIN.	(Month, Day, Year) MARCH 16	Coun	NNSYLVAN	-
œ	FACILITY NAME (If not institution, give s	treet and number)	96. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH	
DIRECTOR	RESIDENCE OF DECEDEN	Doguen	Dail	limore	aly			
E E	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCA	TION			10d, INSIDE CIT	Υ
	MARYLAND ANNE 100. STREET AND NUMBER	ARUNDEL	GLEN BURNIE			1	1 - YES 2 X	
LONGHAL	309 STIEMLY AVE		"	21060		10g. CITIZEN OF	WHAT COUNTRY?	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.	S. ARMED 13. WAS DE	CENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No. 14. BAC	E - American Inc	ilen.
	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES :	2 ∐NO If yes, s	pecify Cuban, Mexico \$ 2 TNO Specif	en, Puerto Ricen, etc.)	Spec	ck, White, etc.	
	15. DECEDENT'S EDUC	WW II	So. DECEDENT'S USUAL OCCUPAT	ZX		WH]	TE	
1	(Specify only highest grade Elementary/Secondery (0-12)		(Give kind of work done during m life. Do NOT use retired.)	ost of working	166. KIND OF BU	SINESS/INDUSTRY		
	12	See Hilloria Co. Co.	CONTRACTOR		CONSTRUC	CTION		
COMPLEIED	17. FATNER'S NAME (First, Middle, Last)		-	and the same of th	ME (First, Middle, Maiden	Sumame)		
1	UNKNOWN 19a. INFORMANT'S NAME (Type/Print)		To Man his control is	UNKNOV				
2	JOHNNY J. SNEERING	ER	309 STIEMLY)	
	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Flora	20b. PL	ACE AND DATE OF DISPOSITION /A	ame of		CATION — City or T		
	4 Donetion 5 Other (Sperity)	CRO	WNSVILLE VETER	ANS	11/17 CRO	WNSVILLE,	MARYLAN	D
	21. SIGNATURE OF FUHITIAL SERVICE LIC	ENSEE	RAYMO	ND C. FIR	GUTY NK FUNERAL	HOME		
	/ Vay L	Ca/	426 C	RAIN HWY	SW GLEN BI	URNIE, MI	21061	
	23. PART i. Enter the diseases, or cahock, or heart feliure.	complications that ceused the List only one ceuse on eech	ne death. Do not enter the men in line.	ode of dying, aud	h aa cardlac or resp	iratory arrest,	Approxim	
11	iMMEDIATE CAUSE (Final disease or condition reaulting in death)	MASSIVE BR	AIN INJURY	B/L SDE			Onset an	
2		FALL DOW			part I. 24a. WAS AN	N	ig an	D
EHIIFICALION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING	PUE TO (OR AS A CO				M. P		
띮	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	INSEQUENCE OF):		1 do	1 M Mor	4	
	resulting in death) LAST	d			The a	pr.		
7 0	PART II. Other significant condition	s contributing to death but	not resulting in the underlying	g ceuse given in	Part I. 24a. WAS AN	AUTOPSY 248	a. WERE AUTOPSY I	FINDINGS
MEDICAL					PERFOR	TMEUT	AWAILABLE PRIOF COMPLETION DF OF DEATH?	OI
							1 TES 2	NO
	DID TOBACCO USE CONTE		PLACE OF DEATH (Check only one		N 🗆 📗			
rn i Siciais:	EXAMINER?	HOSPITAL:	OTHER:		20.000			
	27. MANNER OF DEATH	26e. DATE OF INJURY	26b. TIME OF 28c. IN	JURY AT	NAME OF TAXABLE PARTY.	NJURY OCCURED	. (STe	051
	1 Netural 5 Pending 2 Accident Investigation	1 Mont 5 2 9 5	UNK M 1 —	YES 2 XNO	Dulyect	Fell et	Home	, ,
۱ د	3 Suicide 6 Could not be 4 Homicide determined	HOME (Specify)	At home, farm, street, factory, offic	20	261. LOCATION (Street & 309 Stie	and Number or Rural	Route Number,	
						nly ave	Glen	Bun
	(Check only		ge, death occurred at the time, date ad/or investigation, in my opinion,				aulumin es	
COMPLEIE	29b. SIGNATURE AND TITLE OF CERTIFIER		and a second and a second and a second as	29c. LICENSE NUM				
2 2	ach C	The		D4797		≥ 11-1	(Month, Day, Year)	
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Some Driest)					

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

A. M. D. Critical Care Fellow 22.S GREENE ST

Critical (
32/REGISTRIAN'S SIGNATURE

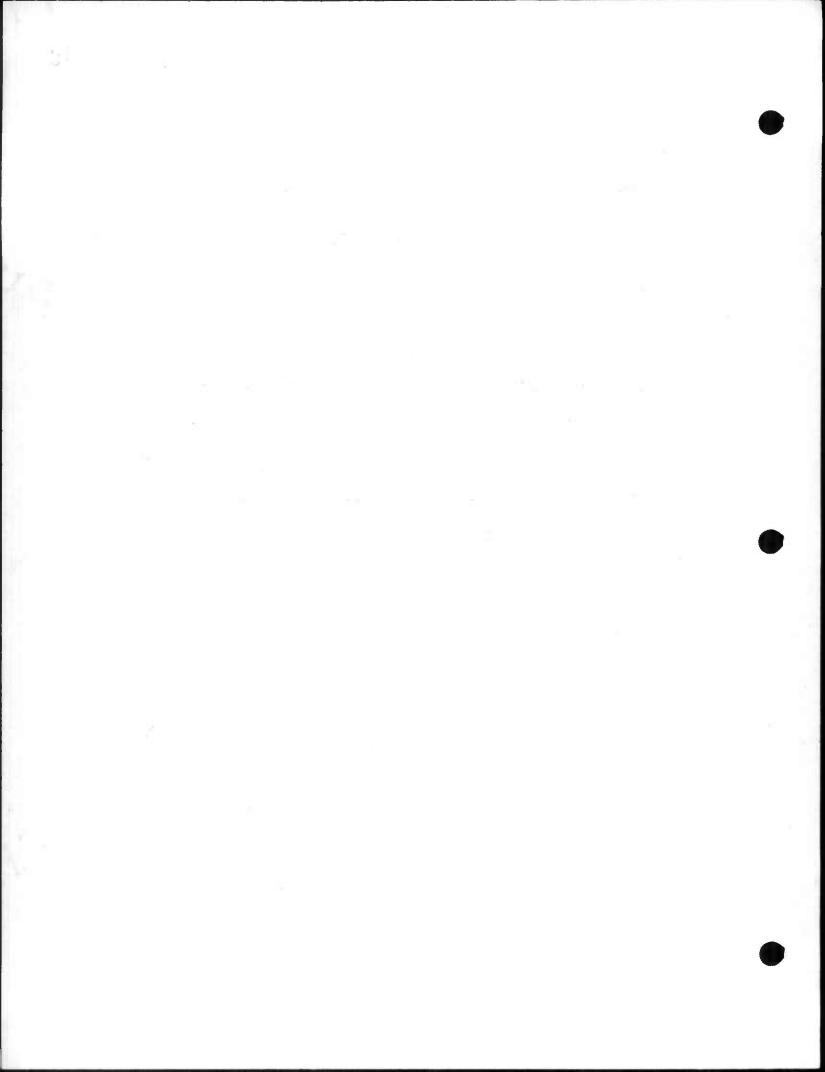
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BALTIMORE, MD #21201

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and within and some secured within and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dent. of Health and Memial Hygiene prior to burial, cremation, or removal.	IMPURIANT. IN 18th 28 IS MARKED, OF 116th 23 SHOWS BIY INJURY, OF OTHER DESIGNATION MORE EXAMINER MUST BE NOTIFIED BY ONCE.
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REGISTRAR		RYLAND / D CEF	RTIFICAT	E OF D	EATH		REG. NO				
1. DECEDENT'S NAME (First, Middle, Last	<u> </u>					2. DATE (OF DEATH	AY Y	EAR 3.	TIME OF DEA	TH
ESTE		PES						5, 199		:35	A
4. SOCIAL SECURITY NUMBER		AGE (In yrs. last bi	MONTHS		UNDER 24 HRS.	7. DATE (Day, Year)	8.	BIRTHPLA Country)	CE (State or I	Foreign
217-38-7337	1 🗆 M 2 💢 F	89	YRS.			June	26,			land	
99. FACILITY NAME (# not institution, give Meridian Perring RESIDENCE OF DECEMENT			9b. CI1	Parkvi		EATH		9c. COUNTY	OF DEAT		
10e. STATE 10b. COUN	ITY		IOc. CITY, TOWN	OR LOCATION						I. INSIDE CIT	v
Maryland 100. STREET AND NUMBER	N/A			timore					1 [LIMITS?	
6304 Fernbank Av	***			101. ZIP				10g. CITIZEN		COUNTRY?	
11. MARITAL STATUS	12 WAS DECEDENT S	VED IN II C. ADME	n T40	WHO DECEMB	21214			US			
1 Never Married 2 Married 3 N Widowed 4 Divorced	FORCES? 1	YES 2 NO	13	If yes, specify 1 YES 2	Cuban, Maxica	an, Puerto R	(Specify Yer	RACE — American Indian, Black, White, atc. Specify: White			
15. DECEDENT'S ED	DUCATION	16a. DECEI	DENT'S USUAL	OCCUPATION		16b.	KIND OF BU	SINESS/INDUS		uirce	
(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give i	kind of work done NOT use retired.	e during most of)	working	1000					
8		Foo	od Prep	arer			Hos	pital			
17. FATHER'S NAME (First, Middle, Last)					MOTHER'S NA	AME (First, M					
Frederick Fonde	elheit				Flore	nce (unkno	wn)			
19a. INFORMANT'S NAME (Type/Print)		19b. M	IAILINO ADDRES	SS (Street and N					de)		
Henry E. Sipes		63	304 Fer	nbank i	Ave.,	Balti	more,	MD 2	1214		
20a. METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei	moval from State	20b. PLACE AND	DATE OF DISPO	SITION (Name of		DATE		CATION — City		Stata	
4 Donation 5 Dother (Specify)		New Cat	:hedral	Cemete	erv	11/1	8 Ba	ltimore	e, MI)	
21. SIGNATURE OF FUMERAL SERVICE L	LICENSEE		22	. NAME AND A	DORESS OF FA	CILITY					
1 /K Sur	(Att 2			LTENBU							
23. PARTA. Enter the diseases, or shock, or haert failure	complications that co	eused the death	n. Do not ente	009 Har	of dying, suc	ch sa cerdi	ec or respi	ratory srrest	MD	Approxim	nate
shock, or haert failure	. List only one cause	on eech line.					-	T - A -	1	interval E	etwe
										Onset an	d Da
disease or condition	AY	rythmia								Onset an	d De ✓
disease or condition resulting in death)	DUE TO (OF	TAS A CONSEQUE	NCE OF):				· <u>-</u>			Onset an	d De ✓
resulting in death)	DUE TO (OF	Spirat	ince of):				·			Onset an	~
Sequentially list conditions, if any, leading to immediate	DUE TO (OF	Spirat	INCE OF):		enm					47	4
resulting in death) Sequentially list conditions,	DUE TO (OF	R AS A CONSEQUE	ENCE OF):							47	~
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REG NO

2. DATE OF DEATN

Navember

Madeline Frances Straight

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

5. SEX

A SOCIAL SECURITY NUMBER

1 -

DIVISION OF VITAL RECORDS, P.O. BOX 6876

?. DATE OF BIRTH (Month, Day, Year) DAYS MONTHS 1 M 2 F 78 235-16-5637 June 4. permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 8237 Peach Orchard Road Dundalk DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Dundalk Baltimore Maryland FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 21222 8237 Peach Orchard Road the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMEO retained by the hospital or attending physician. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.) FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 21 Married 1 YES 2X NO Specify: BY 3 Widowed 4 Divorced use as 1 ETED 15. OECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION t6b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Į Elamentary/Secondary (0-12) College (1-4 or 5+) COMPL page 5 should be detached 12 Years Housewife Own Home once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) ä Edward Myers Lena McCullough notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8237 Peach Orchard Road Dundalk, MD Swinburn F. Straight 24 hours after death. Page 6 may be pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, HOLLY HILL Mem. Pk. 11/15/95 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE anone 7922 Wise Ave. Dundalk, MD 21222 n by the fremoval. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory strest, ahock, or heart failure. List only one cause on each line. filled in I IMMEDIATE CAUSE (Final ASCVD. Arbinoscherte, Carliovan Dines event, the disease or condition_ reaulting in deeth) COM ARTERY DISEans executed burial, CORONARY traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 2 If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury the attending physician Mental Hygiene prior to certificate be other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST 0 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL and t any Signed | Health a 1 TYES 2 NO t. of Heal DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: OR ATTENDING PHYSICIAN: The law has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) certificate h h the State 1, or item OTHER:
4 □ Nursing Nome 5 KRealdence 8 □ Other (Specify) HOSPITAL: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 28b. TIME OF INJURY 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED with 1 marked, 1 Netural 2 Accident 5 Pending 1 YES 2 NO BY After 1 death 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 8 Could not be determined .60 DIRECTOR: A hours after d COMPLETED 4 Nomicide 28 Hem 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL D WITHIN 72 h TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and menner se stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE MTO enn D21859 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print) 67 10 Hololas Aven Ball MB 21222 MonAmmado (Adim) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S MIGNATURE tti

3. TIME OF OEATN YEAR 6:30 AM M 1994 8. BIRTNPLACE (State or Foreign Country) West Virginia sc. county of DEATH
Baltimore tod. INSIDE CITY 1 TYES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. White 20c. LOCATION - City or Town, State Middle River. MD Approximata Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 TYES 2 NO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year)

DNMH-18 Rev 1/89

21-27 N.Monroe ST

Approximate interval Between Onset and Death one week

three weeks

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

		1. DECEOENT'S NAME (First	, Middle, Last)									2. DATE OF DEAT	Н		3. TIME OF DEATH
		WILLIAM SMITH NOVEMBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in use lost bisthelms) SE INDER 1 VEAR SECURITY NUMBER OF DIFFERENCE OF DIFFE							ER 5.1	995	2:15 a				
10		213-78-16	99	1½ M 2 🗌 F	3.	3	YRS.	MONTHS	DAY	8 HOURS	MIN.	12-11	<u>~</u> 61	Mar	yland
should	_	9e. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY	r, TOW	N OR LOCATI	ION OF DE	ATH	9c. CO	9c. COUNTY OF DEATH		
60	5 B	THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY										N/A			
, S	ᇤ	18e. STATE	10b. COUNTY				10c. CITY								404 1110175 01774
Page	DIRECTOR	MD.		N/A						ore					10d. INSIDE CITY LIMITS?
ermit	1 1	10e. STREET AND NUMBER		21/22					T	10f. ZIP COD	E		10a. C	TIZEN OF	1 YES 2 NO
nsit p	EB/	1600 W. M	t. Ro	val Ave	. A1	pt.	308			212	17			U.S	
0 sıcian ial-tra	FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVED IN	11 S ADI	4ED	13.	WAS D	DECENDENT (OF HISPAN	IC ORIGIN? (Specif	y Yee or No-		E — American Indian,
-0020 ing physician. the burial-transit permit. Pages 1, 2,	ВУ Г	1 Never Merried 2 3 Widowed 4 Divo		IF YES, GIVE V	MR OR OA	TES TES	0			Specify Cube (ES 2 NO		, Puerto Ricen, atc	.)		etk, White, etc.
™ 5 %			EDENT'S EDUC	ATION				1						<u> </u>	DIACK
		(Specify only	y highest grade	completed)		(G)	EDENT'S I	ork done	durina	MOSt of worki	ing	16b. KIND OF	BUSINESS/II	NDUSTRY	
	PLE	Elementary/Secondary (0	J-12)	College (1-4 or 5 -)		orte					Mar	ine B	ase	
YLAND 21 by the hospital or be detached for u at once.	COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)				0100			18. MOT	HER'S NAI	ME (First, Middle, Ma			
Z & & #	BE C	William R	edwoo	d								R. Cros			
MARYLAND retained by the hospit should be detached notified at once.		19e. INFORMANT'S NAME (7				19b	MAILING	ADDRES	S (Stree			loute Number, City or		ip Code)	
60	5	Lillian A	. Joh	nson								t. Bal			21236
ORE, 6 may be ctor, page		20e. METNOD OF DISPOSIT		val from State	20b.	PLACE A	NDDATEO	F DISPOS	SITION	(Name of		OATE 200	LOCATION -	- City or To	own, State
MOR sge 6 ma director, p		4 Donation 8 Other	(Specify)		_ M	t.	Zion	Ce	me	tery	11/	10/95	Balt	Ο.,	MD.
ALTIMORE, death. Page 6 may bu b funeral director, page I. examiner must be		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	0.77	a D	11001	22.	NAME	AND ADDRE	SS OF FAC	,1	721-2	7 N.	Monroe S
~ ~ 2 2		Nout	hou	HUTTI	CF	SP	#Z8I	E	بل ، ن	.Pn1.	тттр	SF/H	Balto	. , M	Monroe S D. 21217
in by remedic		23. PART i. Enter the di shock, or h	iseeses, or c	omplications the	t ceused	the dec	th. Do n	ot enter	the	mode of dy	ing, euch	es cerdiec or n	espiratory s	rreet,	Approximate interval Between
y filled if	Ì	IMMEDIATE CAUSE (Fir disesse or condition				,	1	_	.1						Onset and Dea
를 들은 날		resulting in death)	→ ,		CPCITOR AS A	ore	nal	ta	וען ו	ve_					one wee
6876C ecuted within and completely burial, cremat atic event, t	_		_	DUE 10	(OR'AS A	CONSEC	UENCE OF): 1							#1.00
	CERTIFICATION	Sequentisity list conditi		DUE TO	COR AS A	CONSEO	UENCE OF):	e	ver					Inree wee
BOX cate be en hysician a prior to	S I	cause. Enter UNDERLY	NG	K	GPOS	si's	Sa	100	ma						one year
. 4 4 5 2	Ē	CAUSE (Disesse or Inju that initisted events		DUE TO	(OF AS A	CONSEO	UENCE OF):							
G # # # P	E	resulting in death) LAS			+11		AL	DS	>						ten years
RECORDS, requires that the deapen signed by the att or Health and Menta shows any Injury.		PART II. Other significe	nt conditions	contributing to	deeth bu	t not re	euiting ir	the ur	nderly	ring ceuse (given in I	Part I. 24s. WAS	AN AUTOPS	/ 24b	. WERE AUTOPSY FINDING
DRC that the	MEDICAL	1 4	chitis -									PEF	FORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
RECOI requires that een signed of Health a shows am												' '	S 2 NO		OF DEATH?
AL RE he law requ has been be Dept. of i		DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF	DEAT	H YES	S 🔲 I	NO	□ UNC	ERTAIN	R			1 125 2 N NO
VITAL I	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?					OF OEATI	H (Check	only or						
F VIT, SICIAN: Th certificate the State t, or iten	YS!	1 TYES 2 NO		HOSPITAL:	ER/Outper	tlent 3		OTHER		ome 5 🗆 Re	esidence (B C Other (Specify)			
PHYSIC this cer with th	H	27. MANNER OF DEATH		28a. DATE OF (Month, D	INJURY ay, Year)		28b. TIME INJU	OF JRY		INJURY AT WORK?		28d. DESCRIBE NO	OW INJURY O	CCUREO	
ON OI DING PHYS After this death with	B≺		Pending Investigation				1.500	М	_	YES 2	NO				
VISION OF VITAL ATTENDING PHYSICIAN: The law ECTOR: After this certificate has b s after death with the State Dept 128 is marked, or item 23			Could not be determined	28e. PLACE O building,	F INJURY - atc. (Specif	— At hon	te, ferm, at	reet, fect	lory, of	ffice		28f. LOCATION (Sti City or Town, S	eet end Numb tele)	er or Rural I	Route Number,
DIVISION OR ATTENDING F DIRECTOR: After death Hem 28 is man	COMPLETED	A4 - 050715150							_						
# 3 k k	MP	(Check only		MAN: To the best of											
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	8			t: On the deale of el	temination	end/or Ir	veatigation	, in my c	pinion	, death occur	red at the t	ime, date and place	, end due to	the ceuse(e	e) end menner ee stated.
PORT Filed V	BE	296. SIGNATURE AND TITLE	/	MX						29c. LICE	ENSE NUM		29d, DA	TE SIGNEO	(Month, Day, Year)
2 2 3 ₹	2	30. NAME AND ADDRESS OF	DEDECM WHO	COMBI ETED CAU	E OF DEAT	TAL /ITPA	AT /T	0/0			/\ 7	517	- - /	vovem	our 5, 1995
									TMO	NDE NO	D (21200			
		31. PATERILED (Magnife)	to Ch	-600 N	N L	1 S	, r	MLI.	TIMO	KE, M	υ.,	41209			
		NUV I D 133	JU JIM	A 44 14 - 44											

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

DHMH-18 Rev 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page is may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	/-				2. DATE OF	DAY	YEAR_	3. TIME OF DEATH		
	Owen L	5	evi son			Novem		995	0.00	Ам	
DIRECTOR	4. SOCIAL SECURITY NUMBER 166-18-6815	1 🔀 M 2 🗆 F	73 YRS.		HOURS MIN.	7. DATE OF 1 1-9-2	2 (100)	NEW	PLACE (State or Foreign ry) YORK	n	
	9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH N/A				
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INS								10d. INSIDE CITY		
									LIMITS?		
BY FUNERAL	207 S. ANN STREET	101.	101. ZIP CODE 212231			USA					
	11. MARITAL STATUS 1 Never Married 2X Married 3 Wildowed 4 Divorced	R IN U.S. ARMED	2 NO If yes, specify Cuban, N				Spec	14. RACE — American Indian, Black, White, atc. Specify: WHITE			
5	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S U	SUAL OCCUPATION	AL OCCUPATION 16b lone during most of working		. KIND OF BUSINESS/INDUS				
COMPLETED	12 YEARS College (1-4 or 5+)		DISPATCH	retired.)			REENWOOD TOWING		3		
2	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)									
BE C	DAVID L. SEVISON		HAZEL R. BENDER								
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) PO 56 EAST NEW MARKET, MARYLAND 21631								
-	MR. DAVID SEVISON	7							Part Card		
	1 Donation 5 Other (Specify)	cemetery, crematory or oth	b. PLACE AND DATE OF DISPOSITION (Name of metery, crematory or other place) EADOWRIDGE MEM. PARK			OATE 20c. LOCATION — City or Town, State					
	21 SIGNATURE OF FUNERAL SEBURGE LICENSIES AND ASSESSED FROM THE RAL HOME 1201 DUNDALK AVE. BALTO. MD. 212										
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not siter the mode of dying, such as cardiec or reapiratory strest, shock, or haer failure. List on the cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of):								Approximate interval Batwood Onset and D 3 weel	ks	
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTO									INGS	
MEDICAL					1	PERFORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
A	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN VIOLENTIAL DESCRIPTION OF THE PROPERTY OF THE PR										
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO NO NO NO NO NO NO										
PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpetiant 2 ER/Outpetiant 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO									
ETED BY	2 Accident trivestigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJUR building, atc. (Spot		RY — At home, farm, street, factory, office ecity)			281, LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and menner as atlated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and menner as stated.										
TO BE C	Stephanie 1.7	296. SIGNAPURE AND TITLE OF CERTIFIER Stephanie f. Multur, m.D. Resident PO9668 November 6, 1995 Stephanie Neukum, M.D. Department of Neurolosy University of Waryland Haspital									
	Stephanie Neuko	m, M.D. Def	central at of	Neurole	sy Unive	rsity o	+ Warsh	nd t	taspital		
	31. DATNOVALTITO 1995	Jack attendan	IGNATURE Revoluti				,				

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Iteml, Film729, 11/17/95, 1t

WILLIE HENRY

STATE REGISTRAR

t. DECEDENT'S NAME (First, Middle, Last)

3. TIME OF DEATN

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2. DATE OF DEATH DAY YEAR WILLIAM CURTIS PM SMITH NOV.12 1995 20:50 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) AUG 22 1929 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS 1 X M 2 🗆 F MONTHS HOURS 216 24 0288 VIRGINIA 66 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATN DIRECTOR 2702 KEYWORTH AVE. APT.311 N/A BALTIMORE 10c. CITY, TOWN OR LOCATION
BALTIMORE 10e. STATE 10d. INSIDE CITY LIMITS? N/A MARYLAND 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21215 2702 KEYWORTH AVE. APT. # 311 U.S. OF A. the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
tf yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Married BΥ 3 Widowed 4 Dtvorced BLACK use as ETED. 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) ğ Elementery/Secondary (0-12) College (1-4 or 5+) COMPLI N/A LABORER RESTAURANT page 5 should be detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ CURTIS HENRY SMITH CLARA ANN SMITH notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2702 KEYWORTH AVE. #311 MRS. DOROTHY M. BALTO., MD. 21215 SMITH pe METHOD OF DISPOSITION 20c. LOCATION — City or Town, State BALTO . 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Burlel 2 Cremetion 3 Removal from State funeral director, DRUID RIDGE CEM. 11/16/95 Donation 5 Other (Specify) PIKESVILLE, MD. CO. examiner 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEWIS Τ. **GWYNN** LEWIS T. GWYNN FUNERAL HOME 21215 eww V 4517 PARK HEIGHTS AVE. BALTO. In by the nu medical 23. PART I. Enter the diseases, or complication that caused the decade, shock, or heart failure. Liet only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, Approximete Interval Batween ŏ completely filled Onset and Death IMMEDIATE CAUSE (Finel the diseese or condition cremation, Hypertensive Arteriosclerotic Cardiovascular Disease resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) executed prior to burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, laeding to immediate physician cause. Enter UNDERLYING CAUSE (Disease or Injury 8 certificate other the attending phy Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): thet initieted eventa resulting in deeth) LAST 6 death Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the (24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL een signed by the AVAILABLE PRIOR TO that shows any COMPLETION OF CAUSE 1 WES 2X X00 OF DEATH? t 🗆 YES 2 💢 NO has been see Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN O IN UNCERTAIN IN INSPECTION PHYSICIAN: Item 23 AR! 28. PLACE OF DEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL the State certificate HOSPITAL OTHER: 1 XYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA PHYSICIAN: 4 - Nursing Nome 5 Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED with is marked, INJURY this 1X Netural 5 Pending Investigation 1 YES ВҮ death 2 Accident ATTENDING After 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) TO THE FUNERAL DIRECTOR: At be filed within 72 hours after de IMPORTANT: If Item 28 is 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) 8 Could not be determined COMPLETED 4 Nomtcide DR 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner ee stated. HOSPITAL 🗶 💹 EDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date end piecs, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE D JITLE OF CENTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Clay, West) BE 坐 NOV.13,1995 OCME 2 2 3 9 N.ETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 M.D. 32. REGISTRATE SIGNATUR DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

And west

nagrani Sarah Tahun

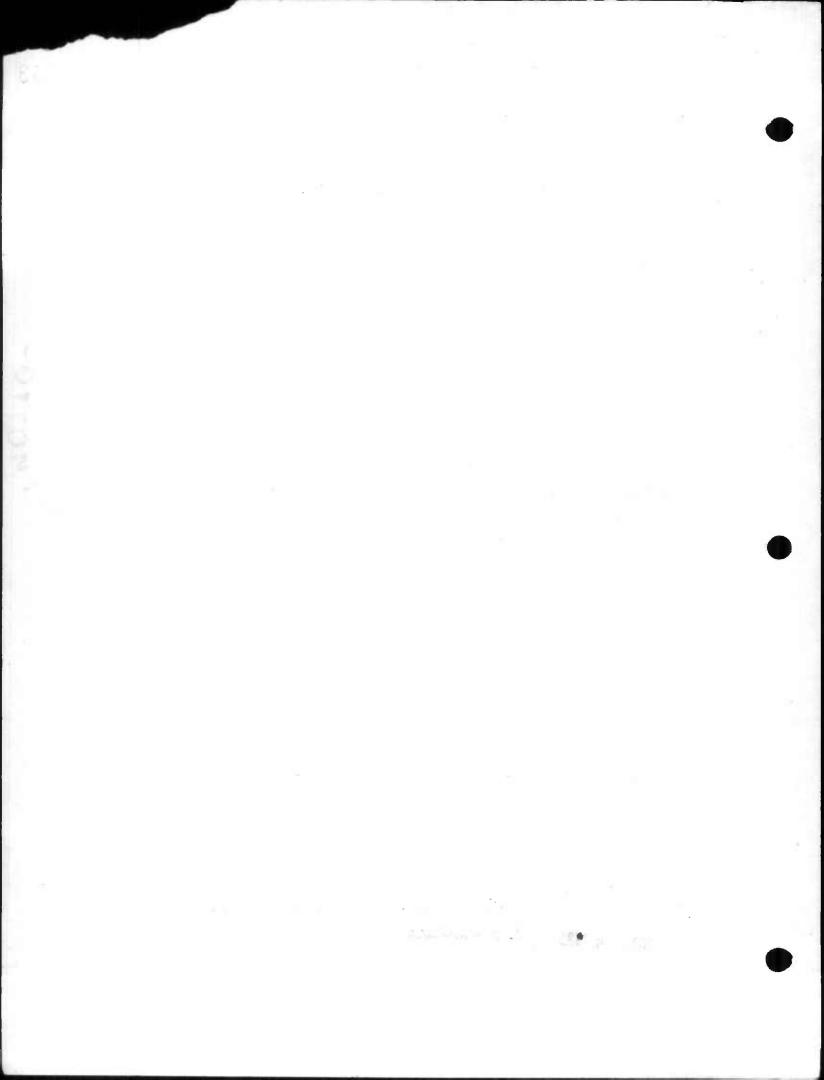
BALTİMORE, MARYLAND 21215-0020 ter death. Page 6 may be retained by the hospital or attending physician. The death of the detached for use as the burial-transit permit. Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit	be filed within 72 hours after death with the State Dept. of Health and Merial Higgere prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED (Morith, Day, Veer)
NOV 1 6 1845

PEGISTRAN'S SIGNATION

1 - STATE REGISTRAR	STATE OF M		DEPARTI		EALTH A		AL HYGIENI REG. NO.	E	95	3466
1. DECEDENT'S NAME (First, Middle, La CARRIE	MA?	Z S	ravro	POULA	S	2. DAT MON NOV	E OF OEATH DA	9,1	YEAR 995	3. TIME OF DEATH 0206 A M
4. SOCIAL SECURITY NUMBER	5. SEX 1 M 2 X F	6. AGE (In yrs. las		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HOURS I	HRS. 7. DAT	E OF BIRTH nth, Day, Year)	1927	6. BIRTHP Country)	LACE (State or Foreign
9a. FACILITY NAME (If not institution, given SINAI HOSPITA				BALTII		OF DEATH	,		ITY OF DE	ATH
SINAI HOSPITA PRESIDENCE OF DECEDENT 10a. STATE 10b. COU	NTY		10c. CITY,	TOWN OR LOCAT	TION					10d. INSIDE CITY LIMITS? 1 YES 2 NO
100. STREET AND NUMBER Homeless		V-16		101	. ZIP CODE			10g. CITI		HAT COUNTRY?
11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 N		If yes, sp	ecify Cuban, I	HISPANIC ORIG Mexican, Puart Specify:	iiN? (Specify Yea o Rican, etc.)	or No—	14. RACE Black, Specify	- American Indian, White, atc. White
15. DECEOENT'S E (Specify only highest gr Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)		(G		SUAL OCCUPATION of done during more retired.)		1	5b. KIND OF BUS	SINESS/IND	USTRY	
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER	R'S NAME (Firs	t, Middle, Malden	Sumame)		
19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING A	DDRESS (Street a	and Number or	Rural Route Nu	mber, City or Town	n, State, Zip	Code)	
20a. METHOD OF DISPOSITION 1	amovel from State		AND DATE OF imetory or othe	DISPOSITION (Na er place)	ame of	0/	ATE 20c. LO	CATION —	City or Tow	rn, Stata
23 PART I. Enter the diseasea, ehock, or heert fallu MMEDIATE CAUSE (Final disease or condition resulting in death)	or complications that re. List only one ceu-	codsed the de		Rm.B0	26-Bal	timore	e, Mary	land	212	more Street 01-1559 Approximete Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in deeth) LAST	DUE TO	MENTAL CO OR AS A CONSEC OR AS A CONSEC	OUENCE OF):							
DID TOBACCO USE COI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 SEYES 2 NO 27. MANNER OF DEATH	tiona contributing to	deeth but not i	resulting in	tha underlyin	g cause glv	en in Part I.	24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE COI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF OEATH	(Check only one)		RTAIN 🗆				
1 X YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1 ☐ Inpetiant 2 ★ 26a. DATE OF (Month, Did 11-9-9)	INJURY	28b. TIME INJUI	RY W	JURY AT ORK?	26d. C	POSURE TO		CURED	
3 Suicide 6 Could not 4 Homicide detarmine	be building,	FINJURY — At he inte. (Specify) UNKNOW		eet, factory, offic	De .		DCATION (Street of try or Town, State) UNK	NOWN	or Rurel A	oute Number,
		my knowledge, de	eath occurred							
29a. CERTIFIER 1 CERTIFYING PA	HYSICIAN: To the best of AINER: On the beels of an		Investigation,	In my opinion,	death occured	at the time, d	ita and piece, an	d due to th	a ceuse(a)	end menner as steted.
29a. CERTIFIER (Check only	MINER: On the beels of a		Investigation,	In my opinion,	29c. LICENS	SE NUMBER . M . E .	ita and piece, an	29d. DAT	E SIGNED	(Month, Day, Year) SER 9,1995



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE	STATE	0F	MARYLAND / DEPARTMENT O	FH	IEA
REGISTRAR			CERTIFICATE (DF	D

1 - STATE REGISTRAR	STATE OF MAK				F DEA		MENIAL	REG. NO.	t		
1. DECEOENT'S NAME (First, Middle, Last)								OF DEATN			3. TIME OF DEATN
MARION JANET	ZIMMERMAN	SIMPS	SON				NOV	EMBER		995	1115 PM
4. SOCIAL SECURITY NUMBER	5. SEX 8. AC	E (In yrs. last b	oirthday)	F UNDER 1 YEA	AR IF UNDE	R 24 HRS.	7. DATE C	OF BIRTH		8. BIRTH	IPLACE (State or Foreign
215-30-7201	1 M 2 X F	63	YRS.	ONTHS DAY	HOURS	MIN.		30, 1	932	Counti M A	RYLAND
9a. FACILITY NAME (If not institution, give st	reet and number)			b. CITY, TOV	VN OR LOCAT	ION OF D		50, 1	_	INTY OF D	
200 ROLLING DA	LE ROAD			BA	LTIMO	RE			В	ALTI	MORE
RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,	1	10c CITY	TOWN OR LO	CATION						10d. INSIDE CITY
MARYLAND BA	LTIMORE			BALTI							LIMITS?
10e. STREET AND NUMBER				7,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101. ZIP CO	DE			10g. CIT	IZEN OF V	WHAT COUNTRY?
200 ROLLING DA	LE ROAD				2	21228	3			U.S	.A.
11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 7				DECENDENT , specify Cub			(Specify Yea	or No-	14. RACI	E — American Indian, k, White, atc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	IF YES, GIVE WAR OF				YES 2 X NO			roam, etc.)		Spec	
15. DECEDENT'S EDUC	CATION	18a. OECE	EDENT'S US	SUAL OCCUP	ATION		16b.	KIND OF BUS	SINESS/IN	DUSTRY	WILLE
(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give		rk done during	SSISTA		1000				MMUNITY
Controller y Controller y (C-12)	4	ВОО	K ST		ANAGE		_ `		OLLE		PHIONITI
17. FATHER'S NAME (First, Middle, Last)					18. MO	THER'S NA	ME (First, M	liddle, Maiden		0.2	
MILLARD I.	ZIMMERMA	N				MAR	RION	GOUL	D		
19a. INFORMANT'S NAME (Type/Print)		19b. I	MAILING A	DORESS (Str	et and Numb	er or Rural	Route Numb	er, City or Tow	n, Stete, Zi	ip Code)	
LAURA L. THOMAS						RIVE		JREL,			
20a. METHOD OF DISPOSITION 1 Burial 24 Cremation 3 Remo	oval from State	20b. PLACE AN	etory or othe	r placel			OATE			City or To	
4 Donation 5 Other (Specify)		CHESAP	EAKE	-			11-1	5 BEL	TSVI	LLE,	MARYLAND
21. SIGNAL SERVICE IN					E AND ADDR			JNERAL	НОМ	E T	NC.
Jam &	· leshte	-Prox	110	736	EDMON	DSON	AVE.	, BAL	T.,	MD 2	1228
23. PART I. Enter the diseases, or of ahock, or heart failure.	complications that cau	sed the deat	th. Do not	enter the	mode of d	ing, suc	ch as card	lac or reapi	ratory as	rreat,	Approximate Interval Between
IMMEDIATE CAUSE (Final	() ·		-								Onset and Death
disease or condition resulting in death)	grain	mila									26 months
	DUE TO (OR A	S A CONSEOU	IENCE OF):	/	Co	~	4				17/ 1
Sequentially list conditions,	DUE TO (OR A	S A CONSEOU	JENCE OF):	my	Co	na	?				X6 month
if any, leading to immediate cause. Enter UNDERLYING											
CAUSE (Disease or Injury that initiated evanta	DUE TO (OR A	S A CONSEQU	IENCE OF):								
resulting In death) LAST	d										
PART II. Other significant condition	a contributing to deat	h hut not rea	niting in	the under	vina causa	aluna la	Part I	24s, WAS AN	ALITOBEV	0.45	. WERE AUTOPSY FINDINGS
TATT II. OTHER SIGNIFICANT CONDUCTOR	a contributing to death	Dut not les	suring in	the under	ying cauae	given in	Part I.	PERFOR	RMED?	240	AMILABLE PRIOR TO COMPLETION OF CAUSE
							_	1 TES 2	NO		DF DEATH?
DID TOBACCO USE CONTI	DIPLITE TO CALICE	OF DEAT	U VEC	NO NO		CEDTAL					1 TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE			(Check only		CERTAI	иПТ				
EXAMINER?	HOSPITAL:			OTHER:	1/						
27, MANNER OF GEATH	28e. DATE OF INJUI		28b. TIME	Nursing OF 28c	INJURY AT	tesidence	6 Other	(Specify)	N.IURY OC	CUBEO	
Netural 5 Pending Investigation	(Month, Day, Yea		INJUI	PY YF	WORK?	□ NO	100.000			JOUNEO	
2 Necident investigation 3 Suicide 8 Could not be	28e. PLACE OF INJU- building, etc. (5	JRY — At home	e, term, atr	eet, tectory,	office			ATION (Street or Town, State)	and Numbe	er or Rural	Route Number,
4 Nomicide determined	January, vas (,500///					City	ii iowii, Stalej			
29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the beat of my kr	owledge, deat	h occurred	at the time,	date and plac	e, and due	e to the ceu	se(a) and mer	ner se st	nted.	
one) 2 MEDICAL EXAMINE	R: On the basis of examina	ition and/or Im	vestigation,	In my opinio	on, death occ	ured at the	time, date	end place, an	d due to t	the cause(s) and manner as stated.
296. SIGNATURE AND TITLE OF CENTURES	1-11	mail	1		29c. Life	CENSE NU	MBER		29d. DA	TE SIGNES	(Monthy Day, Year)
uncul	ujul	rVN			00	43	56		P .	11/1	5/15
30. NAME AND ADDRESS OF PERSON WIN	/	SEATH (ITEM		es Ha	spital	/	900 B	Cafor	to	72	1229
NOV1 6 1995	32 HEGIS RAN'S	NATURE	0								•

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ALTI	leath. P	funeral
BALTI	ter death, P	the funeral
BALTIMORE, MARYLAND 21215-0020	after death. Page 6 may be retained by the hospital or attending physician	by the funeral director, page 5 should be detached for use as the burlal-transit perm

use as the burlal-transit permit. Pages 1, 2, 3 should

detached once.

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DIRECTOR: After the hours after death vitem 28 is mark

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O. BOX 68760 DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed DIVISION OF VITAL RECORDS, P. TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: If II

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH William August 14 Tyc 1995 Nov. 3:00 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year, NOV . 25, 8. AGE (In yrs. last birthday) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 216-18-0112 1 XM 2 - F 1922 Maryland 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 625 Lucia Avenue Baltimore N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY Marvland N/A Batimore 1 KKYES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 625 Lucia Avenue U.S.A. 21229 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES W 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. It yes, specify Cuban, Mexicen, Puerlo Ricen, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 K Merried Specify White BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5+) Tool & Die Maker 12 Western Electric 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Welling Julias Tvc BE 19e. INFORMANT'S NAME (Type/Print) 19b. MANLING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

13 C Warren Lodge Court Cockeysville, Maryland 21030 2 Joan Faulstich Competery, Semantory of Other Place)

Redeemer Cemetery

Redeemer Marvlan

Rattimore. Marvlan 20e METHOD OF DISPOSITION 20b.PLACE AND DATE OF DISPOSITION /Name of Burial 2 Cremation 3 Removal from State Baltimore, Maryland Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
Leroy M & Russell C Witzke Funeral Homes SIGNATURE OF FUNERAL SERVICE LICENSES Dussellen 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. Effer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final myo carliel disease or condition hour resulting in death) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avants. resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN [2] PHYSICIAN: 28. PLACE OF DEATH (Check only one

25. WAS CASE REFERRED TO MEDICAL HOSPITAL . OTHER:
4 | Nursing Home 5 | Raeldenca 8 | Other (Specify) 1 X YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28a. OATE OF INJURY (Month) Day, Year) 28c. INJURY AT WORK? 5 Pending Investigation 1 Natural 1 YES 2 NO 2 Accident

29e. CERTIFIER
(Check only one)

MENICAL EXAMINED: On the best of my knowledge, dash occurred at the time, data and place, and due to the cause(e) and manner as stated.

28a. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify)

2 MEDICAL EXAMINER: On the beels of axaminstion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and menner es steted. 29b. SIGNATURE AND STLE OF CENTIFIER 29c. LICENSE NUMBER

Charles ly from	W Mily
30, NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)

D247 X

29d. DATE SIGNED (Month, Day, Year) 11/14/98

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CHARLES F. GRAMMOR NO, 216 man De N CHOICE CANA, 525, BANT, MD. 2128
31. DATE FILED (MORTH, Day, Year)
NOV 1 8 1865 June d'Aurelian-Randall

31. DATE FILED (Month, Day, Year)
NOV 1 6 1365

8 Could not be

2. DATE OF DEATH MONTH

MEDICAL

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MARIE

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NOVEMBER 15 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH NOV. 7, 1923 412-32-4303 1 M 2 V F HOURS 72 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR permit. Pages 1, 2, 3 MEMORIAL HOSPITAL BALTIMORE UNION RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION BALTIMORE MARYLAND n/a FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 1811 21218 CHILTON STREET funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 TES 2 XNO BY Specify: 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION 6 15. DECEDENT'S EDUCATION (Specify only his П (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5+) COMPL 12 NURSING th 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme) **PATTERSON** HAYWOOD DAISY BE notified 19a. INFORMANT'S NAME (Type/Print)
RANDOLPH 196. MAILING ADDRESS, Strept and August of St., BALTIMORE, MD 21218 2 TEAGLE SR. hours after death. Page 6 may be 9 20e, METHOD OF DISPOSITION
1 🖟 Burlal 2 🗆 Cremation 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must GARRISON OTHER VA 11-20 CEM. 4 Donation 5 Other (Specify) the medical examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 completely filled in by the 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart failure. List only ona cause on each lina. IMMEDIATE CAUSE (Final disease or condition Embolus Monarus reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF burial, (traumatic CERTIFICATION and Sequantially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): 9 the attending physician Mental Hygiene prior to cause. Entar UNDERLYING CAUSE (Disease or injury or other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? HYPERTENSION 1 YES 2 NO 1) IABETES MEULITUS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) marked, or 27. MANNER OF DEATH 26b. TIME OF INJURY 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident 28a. PLACE OF INJURY — At home, farm, streat, fectory, office building, etc. (Specify) 3 Sulcide 60 ED 6 Could not be DIRECTOR: J 4 Homicide 28 COMPLET 1 PCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) end manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, desth occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Associate . Bunkhandt MD mida D. D45862 Pathologist 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimary MD J 21218 UNION MEMORIAL HUSPITAL INDA D. BURKHARDT, MD 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

TEAGLE

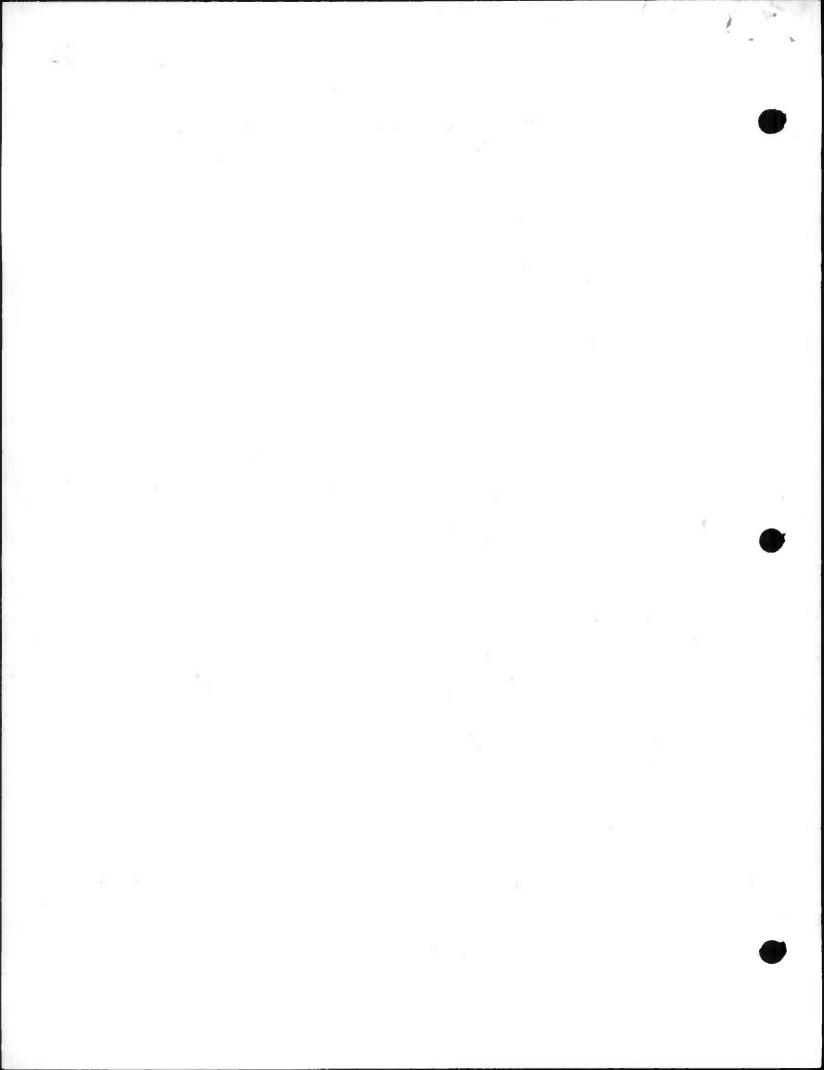
3. TIME OF DEATH 11:20 1995 AM 6. BIRTHPLACE (State or Foreign TENNESSEE 9c. COUNTY OF DEATH n/a 10d. INSIDE CITY
LIMITS?
1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES 14. RACE — American Indian, Black, White, etc. Specify: BLACK 16b. KIND OF BUSINESS/INDUSTRY 20c. LOCATION - City or Town, Stata OWINGS MILLS, MD E. NORTH AVENUE intarval Between Onset and Death Mmediate 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year)

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► NOVEMBER 15, 1995

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ITEMS: 23 PART I, 27,28a-f, PER MEO FILM G-729 11/20/95 t.t

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TO BE	30. NAME AND ADDRESS OF PERSON	WNO COMPLETED CAL						С.М.			NOVE	MBER	5,1995
E COMPL	(Check only	NYSICIAN: To the best of MINER: On the basis of					lasth occu		time, date		nd due to the	cause(a) a	nd manner as state
ETE	4 Homicide datarmina 29a. CERTIFIER A CERTIFIER OF	d	UN	(NOWN	ward on the ct	ma d-1	and stor	and do			UNKNOW		
D BY PH	1 Netural 5 Pending 2 Accident S. Investigati 3 Suicide 6XX Could not	FOUND:	Day, Year) 11/4/95 OF INJURY — At I	UNK	NOW N ^M	1 🔲 '	YES XX	NO	UNKN 281. LOC		and Number		te Number,
HYSIC	XXYES 2 NO 27. MANNER OF DEATN	1 Nospital: 1 Inpettent 2		3 🗆 DOA	OTHER 4 Number	ing Nom	URY AT	aldence		SCRIBE HOW	INJURY OCC	URED	
SICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?				ATN (Check o	nly one)	2 0140						
MED	DID TOBACCO USE CO	NTRIBUTE TO CA	AUSE OF DE	ATH Y	ES 🗆 N	10 F	1 UNC	ERTAI	— N	1 XYES	2 □ NO	OI	OMPLETION OF CAU F DEATH? PYES 2 1 NO
CAL C	PART II. Other significant condi	tiona contributing to	deeth but not	regulting	In the unc	lerlyln	g ceuse (given in	Part i.	24a. WAS AN PERFO		AV	ERE AUTOPSY FIND MILABLE PRIOR TO
ERTIFICATION	Sequentielly liet conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):												
	ehock, or heert failu IMMEDIATE CAUSE (Finel disease or condition reculting in death)	DOXEPIN A	uee on each iir	L INTO	XICATI								interval Betw Onset and D
	23 PART I. Enter the diesess,	or complications the	nt cadsed the	g/ seath. Do	Rm.	.B02	?6-Ba	ltin	nore,	Mary	land	2120	1-1559
	4 Donation 5 Dother (Specify) _ 21. SIGNATURE OF JUNERAL SERVICE	ucegee Ronal	ed wade,	Dir	22. N St.	AME AN	D ADDRES	SS OF FA	CILITY Boar	d-655	w. Bo	altim	ore Str
	20s. METHOD OF DISPOSITION 1	emovat trom Stata		E AND DATE	OF DISPOSIT	Γ ΙΟΝ (Na	me of		DAT	E 20c. LO	CATION — C	city or Town,	, Stata
TO BE	19a. INFORMANT'S NAME (Type/Print)		. 1	96. MAILING	3 ADDRESS	(Street a	nd Number	or Rural I	Route Numi	ber, City or Tow	n, State, Zip	Code)	_
COM	17. FATNER'S NAME (First, Middle, Last)						18. MOTH	HER'S NA	ME (First, I	Middle, Maiden	Sumame)		
PLETE	(Specify only highest gi		(Give kind of fe. Do NOT u	work done du	iring mo	st of workin	g	100	. KIND OF BO	3114239/11401	, 51 HT	
D BY	3 Widowed 4 Divorced	IF YES, GIVE	MAR OR DATES			_ YES	2 [X NO		<i>r</i> :	KIND OF BU	CINECO (MICH	Specify:	Black
FUNER	1836 Druid Hil	12. WAS DECEDEN	NT EVER IN U.S. A			AS DEC		F HISPAN		? (Specify Yei	or No-		American Indian,
AL	10e. STREET AND NUMBER	^ .		1 100	www.	10t.	ZIP CODE				10g. CITIZ		T COUNTRY?
DIRE	10e. STATE 10b. COU	NTY			ry, town of ultimo		ION						d. INSIDE CITY LIMITS? YES 2 N
СТОВ	UNIVERSITY HO		_		BALT	IMC	ORE	CIT	Y				
_	9a, FACILITY NAME (If not institution, git			1000	9b. CITY,				ATH	20, 1	7	TY OF DEAT	Ή
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le	est birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS.	(Month	OF BIRTH Day, Year) 28, 1			ACE (State or Forei
ĺ	JAMES				TA	YLC	OR		NOVE	MBER		95 2	2:35

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

DNMH-16 Rev 1/89

Pages 1, 2, 3

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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95 34668 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Leat) 2. DATE OF DEATH 3. TIME OF DEATH NOV. IONA TURNER 1995 1045 A M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 107971921 DAYS HOURS 219-14-0513 1 M 2 TF 74 Carolina 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3331 DOLFIELD AVENUE DIRECTOR N/A BALTIMORE CITY RESIDENCE OF DECEDENT 10d. INSIDE CITY LIMITS? 1 XYES 2 NO 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND N/A BALTIMORE FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21215 USA 3331 DOLFIELD AVENUE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Maxicen, Puerto Rican, etc.) IF YES, GIVE WAR OR DATE: 1 YES NO Specify BY 3 Widowed 4 Divorced **Black** COMPLETED 15. OECEOENT'S EDUCATION (Specify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) School School 11th Custodian 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Penny Ferebee John Bell 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Roslyn V. Cephas 3811 Fernside Dr. Randallstown, MD 21133 20e. METHOD OF DISPOSITION
1 Souriel 2 Cremation 3 Removal from State
4 Donation 1 Other (Specify) 20c. LOCATION - City or Town, Stete 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Woodlawn Cemetery 11/16 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 23. PART Letter the disease complications that caus the death. Do not enter the mode of dying, such as cerdied or respiratory arrest. **Approximate** shock, or heert List only one ceuse o interval Between **Onset and Death** IMMEDIATE CAUSE (Final Moschote cardiovascular dispus disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF) ceuse. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in daeth) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 WES 2 100 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I PHYSICIAN: 28. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER: 1 X YES 2 - NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 N Residence 6 Other (Specify) BATH TUB 28d. DESCRIBE HOW INJURY OCCURED HAD HEAVET ATTACK 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY UNK 28c, INJURY AT WORK? 1 Natural
2 Accident 11.10.94 M 1 YES ΒY BATTY TUR Investigation 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION /S S Could not be determined COMPLETED 3331 4 Homicide 29n CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledga, death occurred at the time, data end place, end due to the cause(s) end MEDICAL EXAMINER: On the basis of sxs d/or Investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end manner as stated TITLE OF CENTIFIER 29b. SIGNATU 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE O.C.M.E NOV. 11,1995

32 AEGISTRAR'S SIGNATURE

CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withs, at hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--

1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF					MENTAL HYGIEN			
1. DECEDENT'S NAME (First, Middle, Lest)	HORNTO	N					2. DATE OF DEATH NONTH NOV GMB5	2 13'		TIME OF DEATH
4. SOCIAL SECURITY NUMBER 220-20-2665	5. SEX 6. AGE (n yrs. last birthday) 71 YRS.	IF UNDER 1		DURS 24	HRS.	7. DATE OF BIRTH 12-08-2:	3	s. BIRTHPL Country) S. Ca	ace (Stete or Foreign
90. FACILITY NAME (If not institution, give str Liberty Medic				Balt			ATH		NTY OF DEA	тн
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CIT	r. TOWN OF	LOCATION	4				1	Od. INSIDE CITY
MD. N	/A		I	Balt	imo	re			1	LIMITS? YES 2 NO
10a. STREET AND NUMBER	,			10f. ZI	P CODE			10g. CIT		AT COUNTRY?
1624 N. Pulas	ki Street				212	17		1	U.S.	
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	- 11		y Cuben,	Mexice	IC ORIGIN? (Specify Yor, Puerto Rican, atc.)	oa or No—	14. RACE - Black, Specify:	- American Indian, White, atc. Black
15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S (Give kind of v life. Do NOT us	vork done du e retired.)	CUPATION uring most o	d working		16b. KIND OF B		DUSTRY	
8th	0	Housev	vite		_		Own I			
17. FATHER'S NAME (First, Middle, Last)	rona			16			ME (First, Middle, Meide			
William Armst	Long	195 MAII ING	ADDRESS	(Street and			a Wither toute Number, City or To			
Kemp G. Thorn	ton						treet Ba			21217
20e. METHOD OF DISPOSITION	206	PLACE AND DATE	OF DISPOSIT	TION /Name	of		OATE 20c. L	OCATION -	City or Town	n, State
1 Buriel 2 Cremetion 3 Remo	tombment A	rbutus	Men Diece)	. Pa	rk	11/	17/95 A:	rbuti	is,MI	
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	00014	22. N	AME AND	ADDRESS	S OF FA		Ric	lgewo	od Ave. MD.2121
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	Ç	A CONSEQUENCE O	F):	dia	2 9	In De	feeder	'n		Onset and Dec
PART II. Other significent condition	peafeuro			derlying o	ause gl	iven in		N AUTOPSY ORMED? 2 1 NO	0	VERE AUTOPSY FINDING WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTE				ио П	UNCE	FRTAI	<u> </u>			YES 2 NO
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			0.10		. —]			
EXAMINER?	HOSPITAL:	patient 3 DOA	OTHER		5 🗆 Rec	eldence	8 Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIN	JURY M	28c. INJUR WORK 1 YES	TY AT (? 5 2	NO	28d. DESCRIBE HOY	INJURY OC	CURED	
3 Suicide 6 Could not be determined	28e. PLACE OF INJUR' building, atc. (Spe	f — At home, farm, clfy)	street, facto	ory, office			281. LOCATION (Stree City or Town, Sta		er or Rural Ro	ute Number,
(Check only	CIAN: To the best of my know									end manner ee stated.
	2000			17	9c. LICE	NSE NUI	WBER	29d. DA	TE SIGNED	Month, Day, Year)
296. SIGNATURE AND TITLE OF CERTIFIER	14/1)			- 1) ex () '	8			191.
30. NAME AND ADDRESS OF PERSON WH A-UREROL	4419 F	ALLS	A. Print)	B	AL	7(o MD	212	1(191
Aul liberi	O COMPLETED CAUSE OF DI	ALLS	A. Print)	B	AL	7(o MD	212	1(191

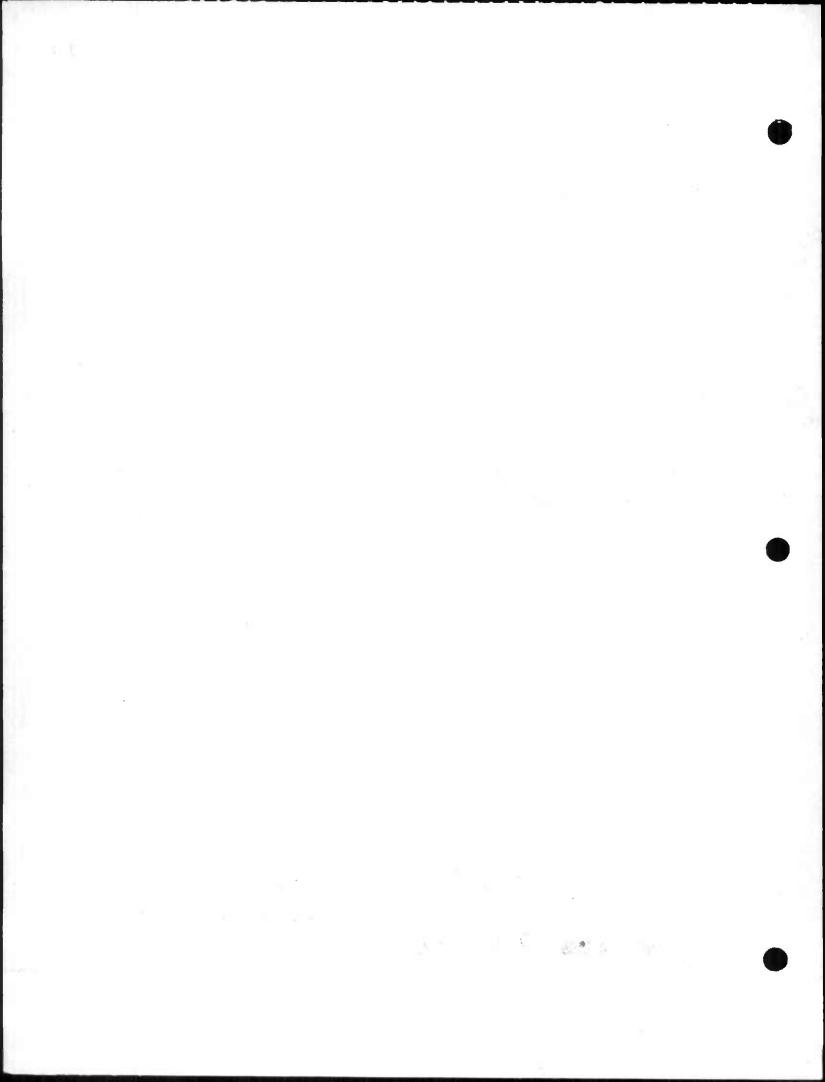
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

UNKNOWN 95-216
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF				MENTAI	REG. NO.	Ē			
	1. DECEDENT'S NAME (First, Middle, Last)		0211111		-		2. DATE	OF DEATH	,	YEAR 3.	TIME OF DEATI	Н
	UNKNOWN #95-216						SEP			1995	02:3	0 A M
į	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday) YRS.	IF UNDER 1	YEAR DAYS	HOURS MIN.	7. DATE (Month	OF BIRTH n, Day, Year)		6. BIRTHPLI Country)	ACE (State or For	eign
1	9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY, 1	TOWN OF	LOCATION OF DE	ATH		9c. COUN	TY OF DEAT	тн	
TOR	LEAKIN PARK WE	ATHERVILLI	E RD.	BAI	LTI	MORE						
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR	LOCATIO	ON				10	d. INSIDE CITY	
											YES 2	NO
RAL	10e. STREET AND NUMBER				101.	ZIP CODE			10g. CITIZ	EN OF WHA	T COUNTRY?	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 1 YES IF YES, GIVE WAR OR D	2 NO	18	yes, spe		F HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — Americe Black, White, etc. Specify: Specify:					in,
	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY									ISTRY		
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)											
COMPLETED												
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme)											
TO BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS ((Street an	d Number or Rural	Route Numi	ber, City or Town	n, State, Zip	Code)		
	20e. METHOD OF DISPOSITION 1	ovel Irom State car	b. PLACE AND DATE metary, crematory or o		TION (Nan	na of	DAT	E 20c. LO	CATION — C	aty or Town	, State	
	21. SIGNATURE OF PUNERAL SERVICE LIC		ide, Der.	22+N	AME ANI	ADDRESS OF FA	CHRAN	d-655	w. Bo	eltim	ore Str	eet
	21. SIGNATURE OF PUNERAL SERVICE LICENSEE RONALD Wade, Dar. 22. NAME AND ADDRESS OF FACILITY BOARD - 655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL CE	PART II. Other significant condition							24a. WAS AN PERFOR	MED?	At Ci	ERE AUTOPSY FI WAILABLE PRIOR OMPLETION OF C F DEATH? YES 2 1	TO
ä	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	OF DEATH Y			UNCERTAI	NX					
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out		OTHER	:	5 🗆 Residence	a Sironh	or (Possibil)	CENII	P		
Ä	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		_	28c. INJU	IRY AT	, A	SCRIBE HOW I	SCENI			\neg
ВУР	1 Natural 5 Pending 2 Accident Investigation	Unknown	Unk	. м	1 🗌 Y	ES 2 NO		cnown				
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, atc. (Spe UNKNOW	ecify)	street, facto	ry, office		281. LOCATION (Street end Number or Rural Route Number, City or Yown, State) Unknown					
COMPLETED	Check only	ICIAN: To the best of my know									ind manner es s	tated.
S m	298. SHANATURE AND TITLE OF CERTIFIE	R O AA	٨		I	29c. LICENSE NU	MBER		29d. DATE	SIGNED (A	fonth, Day, Year)	
00	10 arm	wife WW)			O.C.M.	E.		▶SE:	PTEM	BER 5	199
10	TAFON LOC	KE, MD	111		Sti	ceet, E	Balt	imore	, Ma	ryla	nd 212	201
	31. DATE FILED (Month, Day, Year) NOV 1 6 1995	Shi develo	Reddy									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Item12
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	ICATE (OF [DEATH	-	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)				,			2. DATE OF	DEATH	AY	YEAR	3. TIME OF DEATH	
		Charles				_	164	NOVE		21	1981-	0323 M	
- 2	4. SOCIAL SECURITY NUMBER 212-16-9538	the state of the s	NGE (In yrs. last		IF UNDER 1 YE		HOURS MIN.	7. DATE OF (Month, D	BIFTH ay: Year)	20	Count	IPLACE (State or Foreign	
		1XXM 2 □ F 7	5	YRS.				Oct.1	, 192			more, Maryland	
œ	99. FACILITY NAME (If not institution, give str PENINSULA REGIO		AT CEN	96. COUNTY NTER SALISBURY 96. COUNTY WI						WICO			
5	PENINSULA REGIO	MAL MEDICA	AL CEN	IEK	٥	ALL	JDUKI				W 1 0 0 /		
E I	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR L	OCATIO	ON					10d. INSIDE CITY	
ā	Maryland Worch	nester		Ocean City								LIMITS? 1 YES 2 NO	
A	10e. STREET AND NUMBER					10f. Z	ZIP CODE			10g. CIT	IZEN OF V	WHAT COUNTRY?	
E	504 Nautical Lane						21	842		l	J.S.A	١.	
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARI	MED	13. WAS	DECEN	NDENT OF HISPA	NIC ORIGIN? (S	specify Yes	or No-	14. RACI	E — Americen Indien, k, White, atc.	
BY	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1		•			elfy Cuban, Mexic		n, atc.)		Spec	thy:	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDU								Wh				
									DUSTRY				
P	8th.	College (1-4 or 5+)			cutter			Fo	od I	ndus	trv		
0	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S N)		
BE C	Paul Ernest Ulric	ch						e Louis					
TO B	19e. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS (St	reet and	d Number or Rural	Route Number,	City or Tow	n, State, Zij	p Code)		
ř	Mrs. June F. Ulr:	ich	_ 5	04 N	autica	1 L	ane O	cean Ci	ty,™	laryl	and	21842	
	20e. METHOD OF DISPOSITION 1 M Burtel 2 Cremetton 3 Remo	cal from State			OF DISPOSITIO			OATE				ty or Town, State	
	4 Donetion 5 Other (Specify)		Gardens	of F	aith" Ce	mete	ery Nov.1	1,1995	Bal	Ltimo	re,M	aryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home												
	16.4.3	ssak	N)	11750 Belair Road Kingsville,							Md 21007		
	23. PART i. Enter the diseases, or co	emplicationa that cau	sed the dat	th. Do r	ot anter the	mode	e of dying, aud	ch as cardiac	or reapi	ratory an	rest,	Approximate	
	ahock, or haart failure. List only one cause on each line.											intarvai Between	
	disease or condition resulting in death) = 1. 12 - 7 Rual failure 7 1 2002												
	reading in deadly	DUE TO (OR	AS A CONSEO						-				
z													
Ĕ	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
5	cause, Enter UNDERLYING CAUSE (Disease or Injury												
Ē	that initiated events resulting in death) LAST	DOE TO (OR)	O (OR AS A CONSEQUENCE OF):				•						
E	d.											1	
EDICAL CERTIFICATION	PART II. Other algnificant conditions	contributing to deal	th but not re	suiting	n tha undar	iying o	cause given in	Part I. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
음	2,5,8,16	285 Har	1'6 74	المامر	<u> </u>			1	YES 2			COMPLETION OF CAUSE OF DEATH?	
ME												1 TYES 2 NO	
ÿ	DID TOBACCO USE CONTR	BUTE TO CAUSE	OF DEAT	H YE	S I NO		UNCERTAI	N 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE	OF DEAT	OTHER:	one)							
XS		1 Inpatient 2 ER/			4 - Nursing		5 - Reeldence	8 Other (Sp	pecify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Ye		28b, TIM	URY	WORK	K?	28d. DEŞCRI	BE HOW II	NJURY OC	CURED		
À I	2 Accident Investigation	22- 51 405 05 111	t trock	-			S 2 NO						
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJ building, etc. (Specify)	ne, ferm, s	treet, factory,	office		28f. LOCATIO	N (Street a wn, State)	nd Number	or Rural F	loute Number,	
	29e. CERTIFIER												
M M	(Check only	AN: To the best of my k											
COMPLETED	2 MEDICAL EXAMINER	On the besis of examin	stion end/or in	weatigatio	n, in my opinio	on, deat	th occured at the	time, date end	place, en	d due to It	ne ceuse(e) end menner ee stated.	
H H	296. SIGNATURE AND TITLE OF CERTIFIER					2	9c. LICENSE NUI					(Month, Day, Year)	
2	TO NAME AND COORDER OF THE	COMPLETE					D5661	2		> (1-7	-12	
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	STATE	27) (Type,	Print)	de	un Mi	17.80	21.				
	31. DATE FILED (Month, Day, Year)			, 00	, 201	., 0	- 2 1-11	J 6/0	. (.				
E III	The same of the sa	32. REGISTRAR'S S	AAA AA	3									

E.C.

24 hours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

	FOR 1 - STATE REGISTRAR	STATE OF MAR	YLAND / DEPART			MENTAL	HYGIEN	Ē			
	1. DECEDENT'S NAME (First, Middle, Last) AMANDA	RUBI				2. DATE MONTH CTOB	OF DEATH		AR	ime of Deat	Ам
	4. SOCIAL SECURITY NUMBER NONE 96. FACILITY NAME (It not institution, give second)	1 🗆 M 2 🗔 F	YRS.	ONTHS DAYS ON CITY TOWN!	IF UNDER 24 HRS. HOURS MIH. OR LOCATION OF DE	7. DATE (Month OCT.	OF BIRTH , Day, Year)	6. 6	Country) ELAWA	E (State or For	ыgп
FOR	ATLANTIC GENER							WORC		ΞR	
DIRECTOR	10a. STATE 10b. COUNT		10c. CITY,	10c. CITY, TOWN OR LOCATION BISHOPVILLE						INSIDE CITY	
	100. STREET AND NUMBER 9829 HOTEL ROA				. ZIP CODE 21813		=	10g. CITIZEN	OF WHAT	YES 2 X	10
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2 V NO	S. ARMED 13. WAS DECENDENT OF HISPANIC (2 V NO If yes, specify Cuban, Maxican, P			Puarto Rican, atc.) Black, Specify:				
	15. DECEDENT'S EDL (Specify only highest grade	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			ON st of working		XICAN KIND OF BUS	INESS/INDUST	'RY	WHITE	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	ONE			NONE					
00 =	17. FATHER'S NAME (First, Middle, Last) MARC			18. MOTHER'S NA			Surneme) _SALIN	AS			
TO BE	19a. INFORMANT'S NAME (Type/Print)				and Number or Rurei	Route Numb	ber, City or Town	n, State, Zip Coo	ie)		
	MARCO VALDERAS 200, METHOD OF DISPOSITION				OAD, BIS	-					
	1 💢 Burial 2 🗆 Cremation 3 🗆 Ran 4 🗆 Donation 5 🗆 Other (Specify)		206. PLACE AND DATE OF	CEMETER	Y	10/		CATION — CRY LBYVIL			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			NGS FUNE		HOME,	SELBYV	ILLE.	, DE	
CERTIFICATION	23. PART I. Enter the diseases, or complications that Caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Congenital Heart Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
PHYSICIAN: MEDICAL CERT	PART II. Other significant condition		OF DEATH YES	5 □ NO □		1 YES		MED?	CON OF I	E AUTOPSY FILLABLE PRIOR : IPLETION OF CO DEATH? YES 2	TO AUSE
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	HOSPITAL:		OTHER:		4 C 04					
	27. MANNER OF DEATH	28e. DATE OF INJU (Month, Day, Ye	RY 28b. TIME	OF 28c. IN.	NO 5 Rasidenca IURY AT ORK? YES 2 NO			NJURY OCCUR	ED	-	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE OF INJ building, etc. (URY — At home, farm, atr Specify)				ATION (Street or Town, State)	and Number or F	Rural Route	Number,	
COMPLET	and the same	SICIAN: To the best of my k							ause(a) and	menner aa s	ated.
BE	290 SIGNATURE AND TITLE OF CERTIFIE	orke M	D		29c. LICENSE NU		. 00	29d. DATE SIGNED (Month, Day, Year) CTOBER 26, 1995			5
5	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	111 Penr		et, Bal						
D.	NOV1 6 1995	32 REGISTRAR'S	anature and all								

TO THE FUNERAL UR AN EXPLORAN: The law requires that the death certificate be executed within 4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be detached for use as the burlat-transit permit.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notiffed at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUNERAL DIRECTOR

ITEMS: 23 PART I, II,	PER DR. FILM	4 G-729 11/16	5/95 t.t			20	0401		
1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART			MENTAL HYGIEN REG. NO.	_			
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DO		3. TIME OF DEATH		
J.	ACOB va	n OPSTAL			NOV. 11	. 199			
4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPLACE (State or Foreign Country)		
213-44-7783	X M 2 □ F	82 YRS.	ONTHS DAYS	HOURS MIN.	SEP 29, 19	913	HOLLAND		
9a. FACILITY NAME (If not institution, give street	and number) BLDG	. 1	b. CITY, TOWN C	R LOCATION OF DE		TY OF DEATH			
713 MAIDEN CHOICE		1107	CATONS	VILLE		BAI	LTIMORE		
10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. PSIDE CITY LIMITS?		
MARYLAND BALTIMORE CATONSVILLE									
10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WH									
713 MAIDEN CHOICE	LANE APT.	1107, BLI	G. 1	21228		Н	OLLAND		
	. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yas		4. RACE — American Indian.		
1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 YES			2 NO Specify	n, Puerlo Rican, etc.) /:		Bleck, White, atc. Specify: WHITE		
15. DECEDENT'S EDUCATI (Specify only highest grade con		18a. DECEOENT'S U	SUAL OCCUPATION MORE		16b. KIND OF BU	SINESS/INDU			
	College (1-4 or 5+)	life. Do NOT use	retired.)	st or working	COMMUN	VITY C	COLLEGE OF		
	5+	PROFESS	OR OF M	USIC	I I	BALTIM	IORE		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Surname)			
ANTONIUS van OF	?STAL			AAGJE	KOEKKOE	EK			
19a. INFORMANT'S NAME (Type/Print)		19b, MAILING A	DDRESS (Street e	nd Number or Rural i	Route Number, City or Tow	n, State, Zip (Code)		
ENGELINA van OPSTAI							. MD 21228		
20a. METHOD OF DISPOSITION 1	I from State C6	ob. PLACE AND DATE OF emetery, crematory or othe CHESAPEAKE	er place)				Ity or Town, State		
21, SIGNATURE UNERAL SERVICE LICENS	SEE			ID ADDRESS OF FA					
Mules X	tack		STERL	ING ASHI	ON FUNERAL	HOME	I, INC.		
23. PART i. Enter the diaesaes, or com							st, Approximats		
shock, or haart failura. Llat IMMEDIATE CAUSE (Final	l only one cause on		ſ				Intarval Batween Onset and Dasth		
disease or condition resulting in dasth) e.	+ 8112	-ic Fa	2/11/1/	5			>17 mes		
resulting in castil) . e	DUE TO (OR AS	A CONSEQUENCE OF)	- 0100						
b	HEPATITI	S							
Sequantially list conditions, if sny, laading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):							
CAUSE (Disease or Injury									
that Initiated events	DUE TO (OR AS	A CONSEQUENCE OF):							
d									
PART II. Other significant conditions c	ontributing to death	but not resulting in	the underlyin	g cause givan in			24b. WERE AUTOPSY FINDINGS		
CORONARY ARTERY DIS	SEASE				PERFOI		AMAILABLE PRIOR TO COMPLETION OF CAUSE		
						L DE IVO	OF OEATH?		
DID TOBACCO USE CONTRIB	SUTE TO CAUSE	OF DEATH YES	Пиог	UNCERTAI	NITI		1 100 2 100		
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH							
	IOSPITAL:		OTHER:	o 5 Residence	6 Other (Specify)				
27. MANNER OF DEATH	28a. DATE OF INJURY	Y 28b. TIME	OF 28c, INJ	URY AT	28d. DESCRIBE HOW	NJURY OCC	URED		
1 Natural 5 Pending	(Month, Day, Year)) INJU		YES 2 NO					
2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJUI	RY — At home, term, str	eet, tectory, offic	•	28t, LOCATION (Street		or Rural Route Number,		
4 Homicide determined	building, etc. (Sc	raciny)			City or Town, State				
Frank 1	N: To the beat of my kno								
2 MEDICAL EXAMINER: 0	On the beels of examinat	ion end/or investigation	, in my opinion, c	leath occured at the	time, date and place, er	nd due to the	couse(e) end manner ea stated.		
295. NONETURE AND TITLE OF CONTIFIER	- //	0		29c. LICENSE NUI	MBER	29d. DATE	SIGNED (Month, Day, Year)		
JUMMUST / LL	M.16 14	U		032	319	1	11195		
30 HAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF I		4		41001	229			
31, DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG		timo	re, 1	110 61				

3449 W. 1 31. DATE FILED (Month, Day, Year)

12. REGISTRAR'S SIGNATURE

a sea a BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 17 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

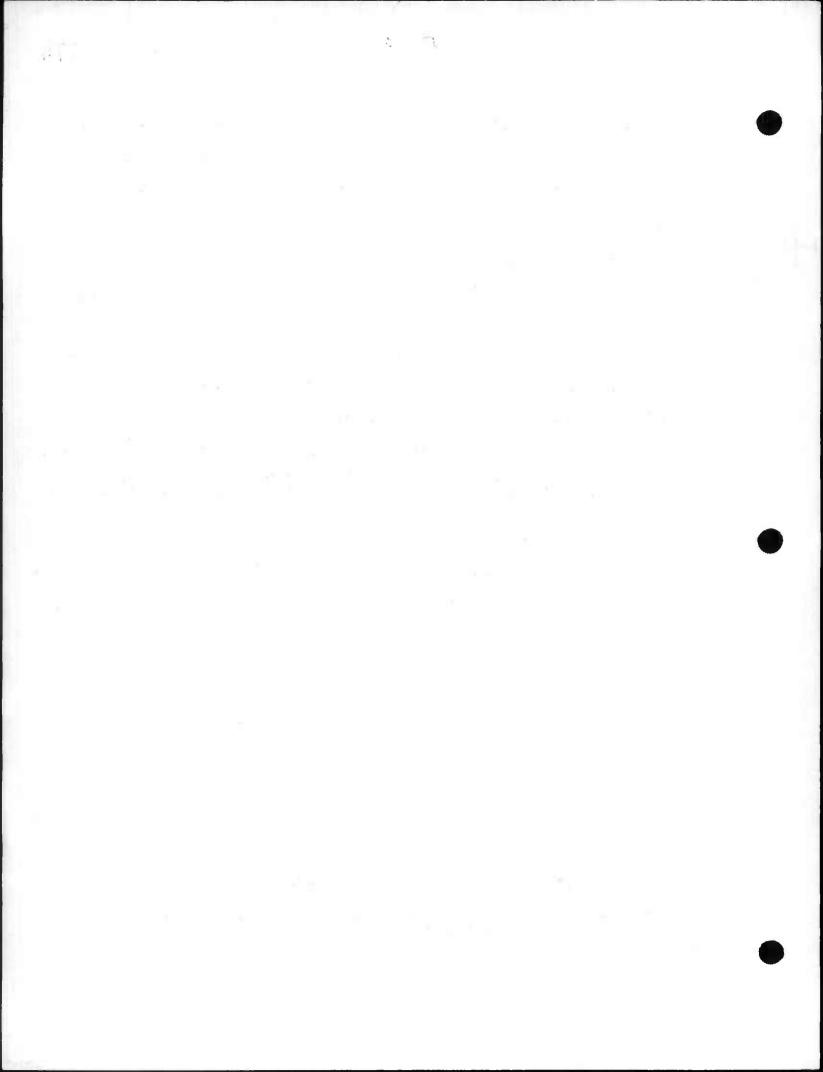
IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CER	TIFIC	ATE O	F DEATH		REG. NO).			
- 8	1. DECEDENT'S NAME (First, Middle, Last)							E OF DEATH			3. TIME OF DEATH	
	EUGENE HARRIS W	VILLIAMS					NON	"ember"	74.	1995	4:20A M	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last bin	thday) =	F UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH	1		PLACE (State or Foreign	
	214-12-8978	1 📉 M 2 🗆 F		YRS.	ONTHS DAY	HOURS MIN.	10	th. Dav. Year)		BALT	O.MARYLAND	
ОВ	90. FACILITY NAME (If not institution, give to VA MEDICAL CENT					N OR LOCATION OF D	EATH			UNTY OF DE	EATH	
5	RESIDENCE OF DECEDENT											
DIRECTOR	MARYLAND BALT	γ ΓΙΜΟRE	10c. CITY, TOWN OR LOCATION BALTIMORE						10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
ا بـ	10a. STREET AND NUMBER					101. ZIP CODE			10g. CI	TIZEN OF W	THAT COUNTRY?	
FUNERAL	2555 WEST LAFAYET			2121				.6			S.A.	
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3)(1) Widowed 4 Divorced	YES 2 NO DE DATES 3-1946	ER IN U.S. ARMED ES 2 NO R DATES 3-1946 13. WAS DECE It yes, spe- 1 YES			CENDENT OF HISPANIC ORIGIN? (Specify Yelecify Cuban, Mexican, Puerto Rican, atc.) 2 X NO Specify:				- American Indian, White, atc.		
딢	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Give k	ind of work	UAL OCCUPA done during	TIÓN most of working	164	b. KIND OF BU	SINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	Coilege (1-4 or 5+)	III. Do	HELI				OMINO	SUGA	AR CO	MPANY	
ő	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA				90		
BE C	ROBERT E. WILLIAMS BERTHA F. WHITE											
10	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
F	YOLANDA ROBINSON		53	52 R	ACEGA1	E RUN COL	_UMB1	A, MAR	YLAND	210	45	
	20a. METHOD OF DISPOSITION 1) Burlel 2 Cremetion 3 Rem	lovel from State	20b, PLACE AND	DATEOF	DISPOSITION	Nama of	DAT	TF 20c. LC	CATION -	City or To	vn. State	
	Deliber 2 Cremetion 3 Removed from State 4 Donation 8 Other (Specify) GARRISON FOREST CEMETERY 11/17/95 OWINGS MILL, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME PA.											
	21. SIGNATURE OF FUNERAL SERVICE LA	enser 1 Ost			ESTER	BROTHERS EUTAW PLA	S FUN	VERAL I	HOME	PA.		
	23. PART I. Enter the diseases, or	complications that ce	used the death	. Do not	enter the r	node of dying, aud	ch aa car	diac or resp	iratory e	reat.	Approximate	
	IMMEDIATE CAUSE (Finel	List only one cause	on each line.								Interval Between Onset and Death	
ł	resulting in death)	Sepsis	AS A CONSEQUE	NCE OD.							10 days	
_	DUE TO (OR AS A CONSEQUENCE OF): Pneumonia										3 days	
5	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
S	cause. Enter UNDERLYING Alzheimer's Disease											
CERTIFICATION	that initiated events resulting in death) LAST											
	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
MEDICAL	TAIN III OURT EIGINICEIN COILGIUN	- Contributing to dea	un but not resu	iung in t	ine ungeriy	ing cause given in	Part I.	24a. WAS AN PERFOI 1 TYES 2	RMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE	
Ĭ									30		OF DEATH? 1 YES 2 NO	
	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEATH	YES	□ NO	☐ UNCERTAI	N 🙀					
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE O	-		19)						
PHYSICIAN:	1 - YES 2 NO	1 M Inpatient 2 - ER	Outpatient 3 🗆 t		THER:	ome 5 Residence	a 🗆 Oth	er (Specify)				
	27. MANNER OF DEATH 1 \(\sum \) Netural \(5 \) Pending	28e. DATE OF INJU	JRY 28	b. TIME O	Y 1	NJURY AT WORK?	28d. DE	SCRIBE HOW	NJURY OC	CURED		
B	2 Accident Investigation					YES 2 NO						
COMPLETED	3 Suicide 8 Could not be determined	28e. PLACE OF IN. building, etc.	JURY — At home, (Specify)	term, stree	et, factory, of	fice		CATION (Street or Town, State)		r or Rural R	oute Number,	
ᆲ	29e. CERTIFIER (Check only 1 CERTIFYING PHYSI	ICIAN: To the best of my I	cnowledge, death o	occurred a	it the time, di	ite end place, end due	to the ca	use(e) end ma	nner as sta	ited.		
S O		R: On the basic of exemi									and manner ea stated.	
	296. SIGNATURE AND TITLE OF CENTIFIE	2				29c. LICENSE NU	MBER		29d. DAT	E SIGNED	(Month, Day, Year)	
	XII					D20215			•	11-	14-95	
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
	KARMACHANDRA NAI			ERRY	POINT	PERRY F	POINT	MD	2190	2		
	"NOV1"61995"	A RECISTRAR	SIGNATINE			<u> </u>						





	1. DECEOENT'S NAME (FIR		John Her RBERT	bert		MONTH		MONTH	NOV, 13 1995		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUM	MBER	5. SEX	v	(In yrs. lest birtho	ly) IF UND	DAYS	IF UNDER	24 HRS.	(Month, Day		8. BH	THPLACE (State or Fore
	215-44-	-			// YR		96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DE					t. of Coli	
ECTOR	Holy Cross	Hospit						Spri		AIH	9c.		gomery
DIREC	100. STATE Maryland	10b. COUNTY	omery			city, town				<u> </u>			10d. INSIDE CITY LIMITS? 1 YES 2 N
FUNERAL	321 Univers		levard #	213		101. ZIP CODE 20901				109. CITIZEN OF U.S.			F WHAT COUNTRY?
æ	11. MARITAL STATUS 1 Never Married 2 3 XWidowed 4 Div		12. WAS DECEDEN FORCES? 1 8/10/36	X YES	2 NO	If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black				NCE — American Indian ack, White, etc. ecity: White			
ETED	15. DE (Specify of Elementary/Secondary	ECEDENT'S EDUC	completed)		(Give kind	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working the Do NOT use retired.)					D OF BUSINES	SS/INDUSTRY	,
	12	(0-12)	5 1/2	+)	Marin	vrine Engineer					ed For	rces	
COMPL	17. FATHER'S NAME (First,		. 1 -			16. MOTHER'S NAME (First, Middle, Meiden Surneme)							
BE at	Herbert Fra. 19a. INFORMANT'S NAME					ING ADDRESS				ecelia Blakeney Route Number, City or Town, State, Zip Code			
TO B	Charles Wri												a 22091
must be	Charles Wright 10719 Cross School Road-Reston, Virginia 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Remove from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cremetory or other place) DATE 20c. LOCATION — City or Tow												
examiner	21. SIGNAFURE OF FONER	21. SIGNATURE OF FONERAL SERVICE LICENSEE Ranald Wade, Dir. 22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory experience.											
음	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory street, shock, or heart feliure. List only one ceuse on sech line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of):												201-1559
went, the medical	iMMEDIATE CAUSE (Fi	neart fellure.	s. Sud	lde	ech line.	o not ente	ac	De	att	n ss csrdlac			Approximet interval Bet
or other traumatic event, the ERTIFICATION	iMMEDIATE CAUSE (Fi	itions, ediete Ying jury	s. Sud	OR AS A	ech line.	o not ente	ac 2ar	De	ath	n ss csrdlac	or reapirator		Approximets interval Bet
any injury, or other traumatic event, the MCAL CERTIFICATION	immediate cause (Fidisesse or condition resulting in dasth) Sequentially list condition from the cause. Enter UNDERLY CAUSE (Disesse or in that initiated events	itions, ediete Ying syrveys ST	B. Sud DUE TO DUE TO	OR AS A	consequence	o not ente	ac ear	Deadle of dy	ath ath Di	SC C S	or reapirator	OPSY 2	Approximet interval Bet Onset and 6 Onset and 6 Ab. WERE AUTOPSY FINE AMAILABLE PRIOR TO COMPLETION OF CAL OF DEATH?
News any injury, or other traumatic event, the MEDICAL CERTIFICATION	immediate cause (Fidisesse or condition resulting in dasth) Sequentially list condition smy, leading to immediate. Enter UNDERLY CAUSE (Disesse or in that initiated events resulting in death) LA:	itions, ediete YING jury ST	DUE TO S. OUE TO DUE TO	(OR AS A (OR AS A death be	CONSEQUENCE CONSEQ	o not ente	er the mo	Dead of dy	ath	SCCS	P WAS AN AUTO PERFORMED	OPSY 2	Approximets interval Bets Onset and E Onset and E 4b. WERE AUTOPSY FIND ARILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
Hem 23 shows any Injury, or other traumatic event, the SICIAN: MEDICAL CERTIFICATION	immediate Cause (Fidisesse or condition resulting in dasth) Sequentially list condition from the sequentially list condition from the sequentially list conditions. Enter UNDERLY CAUSE (Disesse or injust initiated events resulting in death) LA: PART II. Other significations.	itions, ediete YING jury ST Cont conditions	DUE TO B. OUE TO DUE TO A. B. CONTRIBUTE TO CA HOSPITAL:	(OR AS A death be	CONSEQUENCE CONSEQUENCE CONSEQUENCE CONSEQUENCE UT NOT result!	YES DEATH (Check	r the ma	Dead of dy	DI	SCCS	WAS AN AUTO PERFORMED!	OPSY 2	Approximets interval Bet Onset and E Onset and E 4b. WERE AUTOPSY FIND ARILABLE PRIOR TO COMPLETION OF CAL OF DEATH?
Ned, or item 23 shows any injury, or other traumatic event, the PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Lause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) Laurenting in death) PART II. Other signification of the condition itions, ediete YING Jury ST Cont condition:	DUE TO A. S. CONTRIBUTE TO CA	(OR AS A OOR AS A OOR AS A OOR AS A	CONSEQUENCE CONSEQ	YES DEATH (Check	NO L only one) R: rsling Hom 28c, INJ wo	g ceuse g	DI given in insidence	SCCS	WAS AN AUTO PERFORMED? YES 2 M	OPSY 2	Approximets interval Bets Onset and E Onset and E 4b. WERE AUTOPSY FIND ARILABLE PRIOR TO COMPLETION OF CAU OF DEATH?	
28 is marked, or item 23 shows any injury, or other traumatic event, the TED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Lause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) Laurenting in death) PART II. Other signification of the condition itions, ediete YING jury ST Conditions	DUE TO DUE TO DUE TO A. RIBUTE TO CA HOSPITAL: 1 Inpetiant 2 28a. DATE OF (Month, D.) 28a. PLACE O	(OR AS A (OR AS A (OR AS A (OR AS A (OR AS A	CONSEQUENCE CONSEQ	YES DEATH (Check	NO L only one) R: raing Hom 28c. WO 1 1	g ceuse g UNC	DI given in insidence	Part I. 24a.	WAS AN AUTO PERFORMED YES 2 AM Octiv) E HOW INJUR	DPSY 2	Approximets interval Bets Onset and E Onset and E 4b. WERE AUTOPSY FIND ARILABLE PRIOR TO COMPLETION OF CAU OF DEATH?	
If item 28 is marked, or item 23 shows any injury, or other traumatic event, the MPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) CAUSE (Disease or in the initiated events resulting in death) LA: PART II. Other signification of the initiated events resulting in death) DID TOBACCO L 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Accident 3 Suicide 8 Homicide 29a. CERTIFIER (Check only)	itions, ediete YING jury ST CONTROL CO	DUE TO DUE TO DUE TO DUE TO A. B. CONTRIBUTE TO CA HOSPITAL: Imperiant 2 28a. DATE Of (Month, D.) 28a. PLACE O building,	(OR AS A (OR	CONSEQUENC CONSEQUENC	YES DEATH (Checker Injury) Time of injury Mn, street, factors To not entered at the	NO Conty one) R: raing Hom 28c, INJ 1 1 1 tory, offic	g ceuse (DI SINGERTAIN NO and dua	Part I. 24a. 1 Call Describe City or Row to the cause(e)	WAS AN AUTO PERFORMED YES 2 AM (Street and No. No. State)	DPSY 2:	Approximets interval Bets Onset and E Onse
ITEM 28 IS MARKED, OF ITEM 23 Shows any Injury, or Other traumatic event, the PLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) Sequentially list condition resulting in dasth) CAUSE (Disease or in the initiated events resulting in death) LA: PART II. Other signification of the initiated events resulting in death) DID TOBACCO L 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Accident 3 Suicide 8 Homicide 29a. CERTIFIER (Check only)	itions, ediete YING jury ST Cont condition: ST Cont condition: Pending Investigation Could not be determined ATTIFYING PHYSIC OICAL EXAMINER	DUE TO DU	(OR AS A (OR	CONSEQUENC CONSEQUENC	YES DEATH (Checker Injury) Time of injury Mn, street, factors To not entered at the	NO Conty one) R: raing Hom 28c, INJ 1 1 1 tory, offic	g ceuse g UNC UNC I Per I	DI SINGERTAIN NO and dua	Part I. 24a. 1 C S C S S S C S S S S C S S S S C S	WAS AN AUTO PERFORMED YES 2 JM (Street and No. Mar., State) and menner a	DPSY 2.07 OCCURED	Approximets interval Bet Onset and E Onset

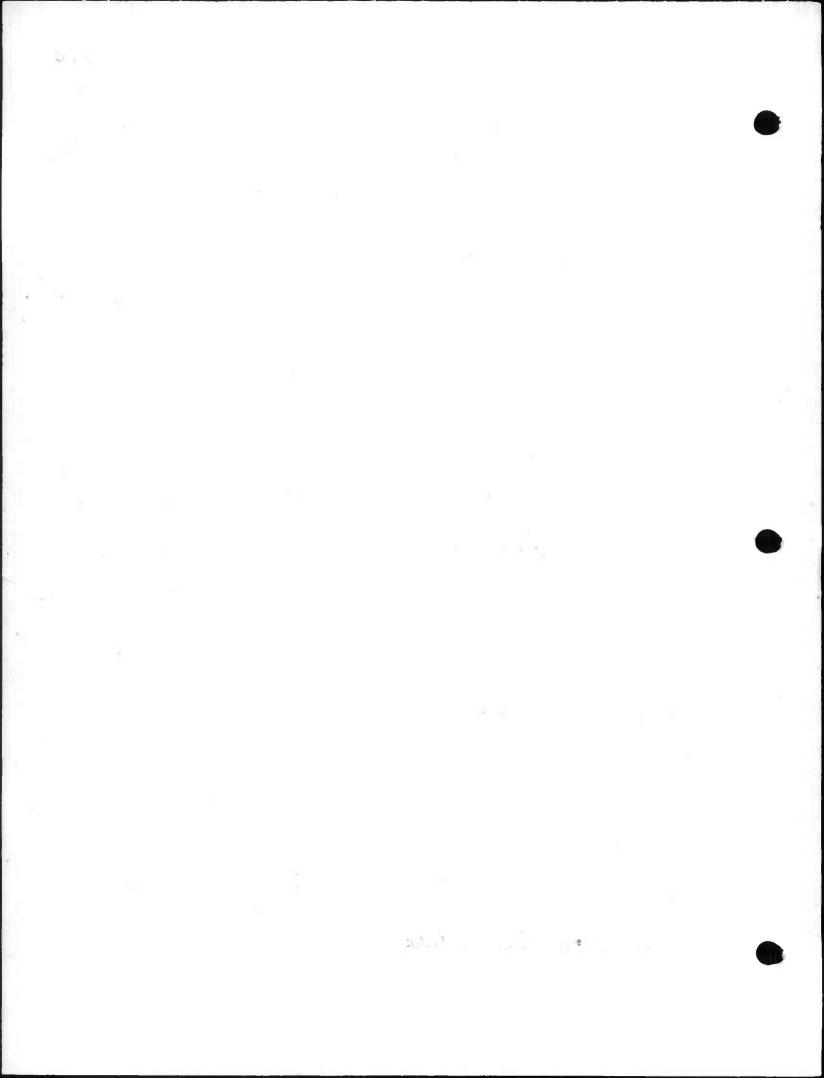
01.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ID HE HUSTIAL DR ALIENDING PRINCIPAL IN A HUSTICIAN. THE IMPRESS THAT THE DEATH CHINICAR DE EXECUTED WITHIN CONTINUE DE TRUE DE TRANSPORTED BY THE FORTING OF THE MAN THE PRINCIPAL OF THE PRINCI
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND / CE	DEPARTMENT OF	HEALTH AND		SIENE a. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)	Carl Worley			2. DATE OF OEA	îТН	3. TIME OF DEATN					
- 4	CAY! W	ORLEY			NOU	9 9	YEAR 2215 M					
1	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. lest	birthday) # UNDER 1 YEAR WONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	TH 8	BIRTNPLACE (State or Foreign Country)					
OR	North Arandel Hosp Gler Burrie BA											
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCA	TION								
DIRECTOR	Maryland		Baltimore				10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
MA	10e. STREET AND NUMBER		.1	H. ZIP COOE		10g. CITIZE	EN OF WHAT COUNTRY?					
ÉF	4304 Ritchie Highwa	У		21225								
BY FUNERAL	11. MARITAL STATUS	. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES	CENDENT OF NISPA pecify Cuban, Mexico S 2 XNO Specif	an, Puerto Rican, a	Ify Yes or No— 14 (c.)	4. RACE — American Indian, Black, White, etc., Specify: White						
8	15. DECEDENT'S EDUCATI (Specify only highest grade com	pleted) (Giv	EDENT'S USUAL OCCUPAT e kind of work done during in	ION lost of working	16b. KINO (OF BUSINESS/INDUS	STRY					
J.	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	Do NOT use retired.)				ì					
COMPLET	17. FATHER'S NAME (First, Middle, Last)		-	16. MOTHER'S NA	AME (First, Middle, A	faiden Surname)						
TO BE	19a. INFORMANT'S NAME (Type/Print)	196.	MAILING AOORESS (Street	end Number or Rural	Route Number, City	or Town, State, Zip Co	ode)					
	20s. METNOD OF DISPOSITION	20b.PLACE Ar	ND DATE OF DISPOSITION (A	lame of	OATE 2	Oc. LOCATION — CIT	ty or Town State					
	1 Donation 5 N Other (Specify) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	from, State cemetery, crem	natory or other place)	namo or		Ju. 200411011 — 011	y or lown, state					
	21. SIGNATURE OF FUNERAL SERVICE LICENS		7. 22. NAME	ND ADDRESS OF FA	ICILITY ,	(FF () D	0+1					
	Same 1	11 Ann 1	State	. Anatomy	Boara-6	55 W. BO	altimore Street					
- 1	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiretory arrest, Approximete											
	anock, or heart failure. Liet only one ceuse on each line.											
	iMMEDIATE CAUSE (Final disease or condition resulting in death) - Arteriosclerotic Heart Disease UNK											
	reaulting in death)	DUE TO (OR AS A CONSFO	UPNCE OFI	CATT	11:	CASIC	UPK,					
-												
CERTIFICATION	Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF):											
CAT	cause. Enter UNDERLYING											
Ĕ	CAUSE (Disease or injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):											
E	resulting in deeth) LAST											
	PART li. Other eignificant conditions co	ontributing to death but not re	eniting in the underlyin	a cours alves in	Don't Oto W	AS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS					
CAL		The state of the s	sorting in the didenty	ig cause given in	P	ERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
EDI					¹□'	ES 2 TINO	DF DEATH?					
Σ	DID TOBACCO USE CO	NITRIBLITE TO CALISI	E OF DEATH A	EC III NO		•	1 TYES 2 NO					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	AIRIBOTE TO CAUSE		LACE OF DEATH (C)								
S	EXAMINER?	OSPITAL:	OTHER:									
Ϋ́	27. MANNER OF DEATN	Inpatient 2 DVER/Outpatient 3 28e. OATE OF INJURY		me 5 Residence		y) HOW INJURY OCCU	PEO					
	1 Natural 5 Pending	(Month, Day, Year)	INJURY W	ORK? YES 2 NO	ZOO. DEGOTABL	TOWN INCOME OCCO	NEO					
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY — At hom			28f. LOCATION (Street and Number or	Rural Route Number,					
삗	4 Nomicide detarmined	building, atc. (Specify)			City or Town,	State)	The state of the s					
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my knowledge, deat	th populary due the time due									
M		in the basis of examination end/or in										
	29b. SIGNATURE AND TITLE OF CERTIFIED											
H	APPLICATIONS AND TITLE OF CENTINES	rhomo	Depute	29c. LICENSE NU	MBER	29d, DATE S	SIGNED (Month, Day, Year)					
၉	30. NAME AND ADDRESS OF PERSON WHO	MPI FTEO CAUSE OF OFATH #YEM	27) (Sing Brief)		7	10	00 10 15					
	William P!	7		95 K	men	ich	21035					
	31. DATE FILEO (Month, Dey, Year)	JE. REGISTRAR'S SIGNATURE	4									



020	physician
BALTIMORE, MARYLAND 21215-0020	care he executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician
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AND	e host
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DIVISION OF VITAL RECORDS, P.O.

TO THE HOSPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTMENT CERTIFICATE		REG. NO.									
1. OECEDENT'S NAME (First, MI	della Lasti UR WIIIIS			2. DATE OF OEATH ON DAY	vember 95	1:35 P.M							
4. SOCIAL SECURITY NUMBER	1 X.M 2 □ F 75	YRS. lest birthday) IF UNDER MONTHS	DAYS HOURS MIN.	3	920 Count								
	96. FACILITY NAME (If not institution, give street and number) Bon Secour Hospital Baltimore Residence of decedent												
10a. STATE	DE. COUNTY	10c. CITY, TOWN O				10d. INSIDE CITY LIMITS? 1 YES 2 NO							
10e. STREET AND NUMBER 11. MARITAL STATUS 1 Y Navyer Married 2 Married 3 M			101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?							
11. MARITAL STATUS 1 X Never Merried 2 Me 3 Widowed 4 Divorce	I IF YES, GIYE WAR OR OATE	2 NO	VAS DECENDENT OF HISPA yes, specify Cuban, Maxico YES 2 X NO Specifi	nn, Puerto Rican, etc.)	or No- 14. RACE — American Indian, Black, White, etc. Specify: Black								
(Consilie only b	ighest grade completed)	6s. DECEDENT'S USUAL OC (Give kind of work done of life. Do NOT use retired.)		16b. KIND OF BUS	NESS/INDUSTRY	- 733							
Elementary/Secondary (0-12	le, Lest)		18. MOTHER'S NA	AME (First, Middle, Maiden S	iurname)	377							
1900. INFORMANT'S NAME (Types Mary Bowser	verini) (friend)		(Street and Number or Rural Park Drive-1			1 21217							
1 Buriel 2 Cremation 4 Donation 5 C Other (S)	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 4 Donation 5X Other (Specify) LN State 21. SIGNATURE OF FUNERAL SERVICE LICENSEE RONALD WARD, DLT. 22. NAME AND ADDRESS OF FACULTY A CET III ROLL STACE.												
21, SIGNATURE OF FUNERAL S	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559												
ahock, or hea	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, ahock, or heart fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Computation for the death.												
If any, leading to immedia	Sequentially liet conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events												
PART II. Other algnificent	conditiona contributing to deeth but			PERFOR	MED?	MANLABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?							
25. WAS CASE REFERRED TO EXAMINER?		PLACE OF DEATH (Check	only one)	N L									
1 VES 2 NO 27. MANNER OF OEATH	1 Inpatient 2 ER/Outpet 28s. DATE OF INJURY (Month, Day, Year)		28c. INJURY AT WORK?	6 Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED								
2 Accident 1m 3 Suicide 8 Ca 4 Homicide ds	ending reatigation	At home, farm, street, fact	1 YES 2 NO	281, LOCATION (Street a City or Town, State)	St. LOCATION (Street and Number or Rural Route Number,								
COOL OTHY	YING PHYSICIAN: To the beat of my knowled					(a) and manner as stated.							
296. SIGNATURE AND TITLE O	F CERTIFIER	M.D	29c. LICENSE NU	IMBER	29d. DATE SIGNE	19 19 (Month, Day, Your)							
30. NAME AND ADDRESS OF	PERSON WHO COMPLETED CAUSE OF DEAT	Maltime 27) (Type, Print)	ou M.Z	2120) /	413							
NOV 1 6	1995 STREGISTRAR'S SIGNAT	Randa II.											

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL	HYGIEN REG. NO.	E			
1. DECEDENT'S NAME (First, Middle, Las	0				2. DATE C	OF DEATH		убар 3	. TIME OF DEATH	
TATTACACATA					NOV		199	YEAR 5	10:08 P.	
4. SOCIAL SECURITY NUMBER			ONTHS DAYS	IF UNDER 24 HRS.		Day, Year)		Country)	ACE (State or Foreign	
215-30-3693	1 🔀 M 2 🗌 F	6Z YRS.			Jan 2	24, 19				
9e. FACILITY NAME (If not institution, give		9	b. CITY, TOWN C	R LOCATION OF DE	EATH		9c. COUNT	Y OF DEA	тн	
325 GWYNN AVE BALTIMORE n/a										
325 GWYNN AVE RESIDENCE OF DECEDENT 100. STATE 10b. COUN Maryland		10c. CITY,	TOWN OR LOCAT	ION				1	Dd. INSIDE CITY	
Maryland r	n/a	1	Baltimo	re			YES 2 NO			
100. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF WHAT COUNTR				
10e. STREET AND NUMBER 325 GWynn Avenue 11. Marital Status			212	229		USA	JSA			
11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT VER IN I	J.S. ARMED 2 NO	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN?	(Specify Yee icen, etc.)	or No — 1	I4. RACE -	- American Indian, White, etc.	
3 Widowed 4 Divorced	March 53 -		1 TYES	2 X NO Specif				Specify:	D1 a cla	
	DUCATION	ISe. DECEDENT'S US	SUAL OCCUPATION	DN .	16b.	KIND OF BUS	INESS/INDU	STRY	Black	
(Specify only highest gra	completed) College (1-4 or 5+)	(Give kind of wor life. Do NOT use I	rk done during mo	st of working						
12th Grade	0011030 (1-4 01 0 1)	Labore	er		Bet	.hlehe	m Ste	el C	orporation	
15. DECEDENT'S Et (Specify only highest gra Elementary/Secondary (0-12) 12th Grade 17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA						
Dewey Wallace				Roberta	Aust	in				
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural	Route Numbe	er, City or Town	n, State, Zip C	Code)		
Heren Marrace		325 Gw	ynn Ave	nue	Balti	more,	Mary	land	21229	
200 METHOD OF DISPOSITION 1-1 Burlel 2 Cremetion 3 Re	emoval from State 20b.F	PLACE AND DATE OF ery, cremetory or othe	r plecel		NOV		CATION — CI			
4 Donetion 5 Other (Specify)	MD	Veteran	Cemeter	y/Garris	on 1	5 Owi	ngs Mi	lls,	Maryland	
21. SIGNATURE OF FUNERAL SERVICE	LICENSER		22. NAME AT 2501	id address of fa Gwynns F	'all's	ter F	unera	1 Ho	mes, Inc.	
many X.	foller	•	Balti	more, Ma	rvlar	nd 21	216			
IMMEDIATE CAUSE (Finel disease or condition reculting in desth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	e. Hypertens OUE TO (OR AS A C DUE TO (OR AS A C C DUE TO (OR AS A C	CONSEQUENCE OF):	terios	clerot	ic Ca	ardio	vasc	ulaı	Onset and Death	
PART II. Other significent conditi	one contributing to death but	t not reculting in	the underlyin	g ceuse given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	A C	/ERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO	
DID TOBACCO USE CON	ITRIBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAI	N					
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		8. PLACE OF DEATH								
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Ves 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpetient 2 ER/Outpet		OTHER:	e 5 [XReeldence	8 🗆 Other	(Specify)				
27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME		URY AT	28d. DE\$6	CRIBE HOW I	NJURY OCCL	JRED		
1 Natural 5 Pending 2 Accident Investigation				rES 2 NO						
a C a										
4 Homicide determined										
one) -	YSICIAN: To the best of my knowle								and manner ee stated.	
29b. SIGNATURE AND TITLE OF CERTIF	TIER //			29c. LICENSE NU	MBER		29d. OATE	SIGNEO (A	Month, Day, Year)	
0	es al			Ε.		NOV. 11, 1995				
DAVID FOWLE						imor			and 2120	
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TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bospital or attending physician.

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1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

	REGISTRAR			CERTIF	ICATE	OF DE	AIH	Ri	EG. NO.					
i	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF D	EATN		1.00	3. TIME OF DEATN		
1	Samuel J. Hugo				Wvnn			MONTH DAY			995	4:20 P M		
								November 14,						
	4. SOCIAL SECURITY NUMBER		last birthday)	IF UNDER 1 Y	EAR IF UI	IDER 24 HRS.	7. DATE OF B (Month, Day	(RTN (, Year)		8. BIRTN Countr	IPLACE (State or Foreign			
	577-42-5009	77-42-5009 TRM2 TF				1100	TO MIN.	Dec 25	10	Pan	nsvlvania			
	9s. FACILITY NAME (If not institution, give street and number)				9b. CITY, TO							9c. COUNTY OF DEATN		
œ	2 53 - 21 10 10 20 10 10 10 10 10 10 10 10 10 10 10 10 10													
2	GBMC			OWSO	1				Balt	imore				
0	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	,		100 007	Y, TOWN OR I	00471011					- 1			
DIRECTOR	IOS. STATE	•		TOC. CIT	i, IOWN ON I	JUCATION						10d, INSIDE CITY LIMITS?		
	Maryland	n/a			Balti	more						t X YES 2 NO		
4	10e. STREET AND NUMBER					101, ZIP (ODE			10g. CIT	IZEN OF V	WHAT COUNTRY?		
FUNERAL	106 East Northern	n Dawlerne					21212			13				
2	100 East NOI CHELL									US				
5	t Never Merried 24 Merried	12. WAS DECEDEN FORCES? 1	YES 2	NO NO				NIC ORIGIN? (Sp		or No-	14. RACE Bleck	E — American Indian, k, White, stc.		
ВУ	F YES, GIVE WAR OR DATES 1 ☐ YES 2 ♣ NO Specify: Specify:										ffy:			
	3 Wildowed 4 Divorced	World W	ar II									Black		
	15. DECEDENT'S EDU		16a.	DECEDENT'S				16b. KINI	D OF BUS	INESS/IN	DUSTRY			
E	(Specify only highest grade			(Give kind of a	work done duri se retired.)	ng most of w	orking							
٦	Elamentary/Secondary (0-12)	College (1-4 or 5+		l a dama	a + /There	.10		177.0	De		e T-	h a		
2		3 ∓		laceme	IIC/EIII	_			-	-	f La	bor		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)					16. R	IOTNER'S NA	ME (First, Middle	s, Maiden S	Sumame)				
BE	Samuel Jaems Wyni	า				Ev	a Car	ter						
	19s. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (S	treet and Nu	mber or Rural	Route Number, C	ity or Town	. Stotu. Zia	p Code)			
2	Evelyn Wynn											ND 21212		
							II Par	Kway	Bal	timo	re,	MD 21212		
	20e. METNOD OF DISPOSITION 1 X Burlet 2 Cremellon 3 Rem	oval from State		CE AND DATE		ON (Name of		NOV	20c. LOC	CATION —	City or To	own, State		
	4 Donetion 5 Other (Specify)		Gova	ns Pre	shyte	rian	Church	17	Ba 1	timo	re.	Marvland		
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE			22. NA	ME AND AD	DRESS OF FA	CILITY MITT	tter	Fun	era1	Homes, Inc.		
	h h P	Rollis)	250	1 Gwy	nns F	alls Pa	arkwa	ay		, 21100		
	sary d.	rous			Ba1	timor	e. Ma.	ryland	21:	216				
	23. PART I. Enler He diseeses, or	complications tha	t caused the	death. Do							rast,	Approximata		
	ahock/or haart failura. List only one cause on asch line.											Interval Between Onset and Death		
	disease or condition s. MULTIPLE ORGAN FAILURE SYNDROME									Oliset and Death				
	resulting in death)	. MULTIPL	E ORC	HAN F	AILUN	2/E S	YNDR	OME				5 d		
				SEQUENCE O	,									
z		ASPIR	ATTOR	U PN	EUMO.	VIA						10 d		
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate b. ASPIRATION PNEUMONIA Due to (or as a consequence of):													
¥	csuse. Entar UNDERLYING	. SMALL	L Bou	166 0	OBSTI	enci	TION					101		
E	CAUSE (Disease or Injury that initiated avants			ISEQUENCE O										
E		. INCARC	EDATE	700	11 2	111/1	1010	1 110	PAL	110		15d.		
ij.		d. TVCTAC	CALIFIC	7070	711	7700	- I - VA	- 1761	2/0/			1,500.		
	PART ii. Other aignificant condition	a contributing to	death but n	ot rasuiting	in the unde	riving cau	se given in	Part i. 24a	. WAS AN	AUTOPSY	24h	. WERE AUTOPSY FINDINGS		
EDICAL						,	9,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFOR			AVAILABLE PRIOR TO		
ă	-							10	YES 2	XHO		COMPLETION OF CAUSE OF DEATH?		
ME												t TYES 2 NO		
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF D	EATH YI	S NO	D XX C	NCERTAI	N 🗆 l						
A	25. WAS CASE REFERRED TO MEDICAL			LACE OF DEA		-								
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER:									
ΥS	1 YES 2 NO	1 Xinpatient 2	ER/Outpatian	t 3 DOA	4 - Nursin	Nome 5	Residence	a Other (Sp	ecify)					
H	27. MANNER OF DEATN	28a. DATE OF (Month, D		28b, TIN	IE OF 28	c. INJURY A	T	28d. DESCRIE	BE NOW II	NJURY OC	CURED			
	1 Natural 5 Pending Investigation					1 YES	2 NO							
BY	2 Culatida	28s. PLACE O	F INJURY A	t home, larm,	street, factory	office		28I. LOCATIO	N (Street a	nd Numbe	or or Rural i	Route Number.		
	4 Nomicide datarmined	building,	atc. (Specify)					City or To	wn, State)					
					-									
집	29s. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of	my knowledge	, daath occurr	ed at the time	, data and p	lacs, and dus	to the cause(a) and men	ner aa ats	sted.			
COMPLETED	one) 2 MEDICAL EXAMINE	R: On the bests of s	kamination and	i/or investigation	on, in my opir	ion, death o	ccured at the	Ilms, data and	placs, an	d dus to I	hs cause(s	s) and manner as atated.		
	ME SIGNATURE AND TITLE OF CERTIFIE					1								
BE			7				LICENSE NUI			29d. DA	TE SIGNED	(Month, Day, Year)		
TO E														
F	O. NAME AND ADDRESS OF PERSON WA													
	JOHN B. RICHARL	SON, MI	1200	YORK	RD 3	WITE	22	LUTHE	RYIL	HE	MD	21093		
										1				
	31. DATE FILED (Month, Day, Year) NOV 1 6 1995	ST REGISTRA	volen-	artall								1		
		1												

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A.P.	as b	Dept	23
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wince 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
CIAN	irtifi	the S	6
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G P	er t	ath v	nart
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DR A	JIRE(OURS	me)
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and the last	-	-	=

	FOR STATE REGISTRAR	STATE OF N		/ DEPAR					MENT	-	YGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Lest) Add Hu Rood 7 100 Port Month Day YEAR 3. TIME OF DEATH MONTH DAY YEAR											3. TIME OF DEATH 5:45 P M				
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday) YRS.	IF UNDER	IF UNDER I YEAR		F UNDER 24 HRS.		E OF BI	OF BIRTH		8. BIRTH Countr	PLACE (State or Foreign y)		
	220≈12≈5437 9e. FACILITY NAME (If not institution, give st		69	THS.	= 100		OR LOCATION OF D			b .	14,1	1926 Ma		ryland		
TOR	113 South Bould		Baltimore City N/A													
DIRECTOR	Maryland 106. COUNTY	10c. CITY, TOWN OR LOCATION						Bal	timo	lity	10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
FUNERAL	100. STREET AND NUMBER		101. ZIP CODE						10g. CITIZEN OF WHAT C							
NS	113 South Bouldi	ARMED	ARMED 13. WAS DECENDENT OF HISPAN								14. RACE	- American Indian,				
B≺	1 Never Merried 2 Married 3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DATES												Black, White, etc. Specify: White.		
品	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	18e,	DECEDENT'S	work done d	CUPATIO	ON st of worki	ing	-10	Sb. KINC	OF BUS	INESS/INC	DUSTRY			
COMPLETED	Elementary/Secondary (0-12) 8 Years	College (1-4 or 5	+)	House		er_					Нои	seke	epin	9		
	17. FATHER'S NAME (First, Middle, Last)							HER'S NA								
8	Phillip Henry Was	gner		19b. MAILING	ADDRESS	/Street e					-	Bre State Zie				
유	John W. Ziegler.	Jr.												1221		
	John W. Ziegler, Jr. 1036 Foxridge Lane Essex, Maryland 2121 208, METHOD OF DISPOSITION 1 (X Burlal 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Holly Hill Mem. Gans. 11/16/95 Middle River, MD															
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	11104	y Im	22.1	NAME AN	me and address of Facility das Ruck Funeral Home of Dundalk, Inc.									
	Dohung Ly,	dels			79	922	Wise	Ave	1	Duni	dalk	. MD	21	lk, Inc. 222		
	23. PART I. finter the diveases, or contact, Dr freet fellure.	complications that List only one ceu	t ceused the	death. Do ine.	not enter	the mo	de of dy	ring, suc	ch aa ce	rdlec	or reepl	ratory en	reat,	Approximate Interval Between Onset and Daath		
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a(lai	le	m	yo.	cor	de	0	uj	fac	tr		Onset and Death		
_	DUE TO (OR AS A CONSEQUENCE OF):															
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO	(OR AS A CON	SEQUENCE O	F):	,										
FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c DUE TO	(DR AS A CON	SEQUENCE C	F):		_									
FR	resulting in deeth) LAST	d														
2	PART II. Other eignificent condition	s contributing to	desth but no	ot resulting	in the un	derivino	g Ceuee	alven in	Part I.	24a.	WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS		
PERFORMED? 1 YES 2 NO OF									AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?							
									1 □ YES 2 □ MG							
IAN	25. WAS CASE REFERRED TO MEDICAL			LACE OF DEA			3 0111	CERTAI								
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Oulpation	3 🗆 DOA	OTHER 4 Nurs		1e 5 □ R	eeldence	6 🗆 Ot	her (Spe	iclfy)					
2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide determined									28d. DESCRIBE HOW INJURY OCCURED							
									ıral Route Number,							
PLE	29a. CERTIFIER 1 DERTIFYING PHYSI	CIAN: To the best of	my knowledge	, death occur	red at the ti	me, deta	end plac	e, and due	to the c	ause(s)	and mar	ner ee sta	ted.			
29a. CERTIFIER (Check only one) 29a. MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner ee stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause (s) and manner ee stated.										he ceuse(e	e) end manner es stated.					
BE	29b. SIGNATURE AND TITLE OF CERTIFIES Rounded a	tta	vivo	M	0		29c. LIC	ENSE NU	MBER F09	.7		29d. DAT	E SIGNED	(Month, Day, Year)		
10	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	SE OF DEATH (ITEM 27) (Type	s. Print)	06	W. 1	Poni	+R	d.	B	olt,	Md	. 21274		
	31.NOV1 6 1995	REGISTRA	Said I	E												

STANDARD OF SELECTION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

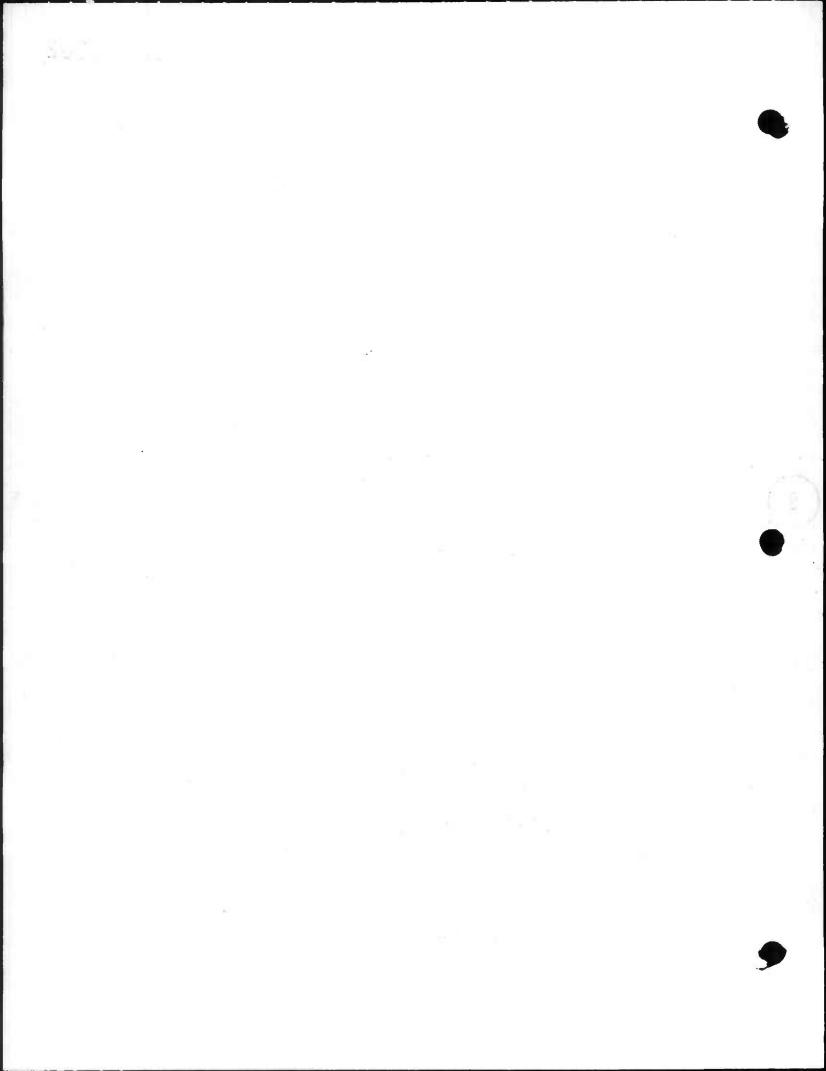
31. DATE FILED (Month, Day, Year)

2. REGISTRAR'S SIGNATURE

for STATE REGISTRAR	STATE OF N			MENT OF			MENTAL HYGI REG.			
1. OECEDENT'S NAME (First, Middle, Las SOL	(1)	ZAC	GER				2. DATE OF DEATH MONTH NOVEMBE	DAY	YEAR 1995	3. TIME OF OEATH 1:41pm
4. SOCIAL SECURITY NUMBER 059-12-4167	5. SEX	8. AGE (In yrs. les		IF UNDER 1 YEA	_	ER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea	r)	8. BIRTI Count	IPLACE (State or Foreign ry)
9a. FACILITY NAME (If not institution, give			1251111	9b. CITY, TOW	N OR LOCAT	TION OF DI	AUG. 18		UNITY OF D	YORK
		λΓ		OLNE						
RESIDENCE OF DECEDENT	THE HODITI	AU		OLIVE.				P	ONTG	OMERY
MONTGOMERY GENER RESIDENCE OF DECEDENT 10a. STATE 10b. COU NEW YORK	łTY			TOWN OR LO						10d. INSIDE CITY LIMITS?
	QUEENS		E	LUSHI						1 YES 2 NO
10e. STREET AND NUMBER 14205 ROOSEVELT 11. MARITAL STATUS 1. Marer Marriad 2. Marriad	2100			- 1	10f. ZIP CO			10g. Ci	TIZEN OF	WHAT COUNTRY?
14205 ROUSEVELT	14205 ROOSEVELT AVE. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED					354			US	
1 Never Merried 2 Married	FORCES? 1	YES 2 X	NO NO	If yes	specify Cut	en, Mexica	NIC ORIGIN? (Specifi in, Puarto Rican, etc.		14. RAC Blac	E — American Indian, k, White, atc.
2 Widowed 4 Divorced	IF YES, GIVE V	WAR OR DATES		1 0	ES 2 X	Specif	У.		Spec	WHITE
15. OECEOENT'S E		16a. DE	CEDENT'S	USUAL OCCUP	ATION		16b, KIND OF	BUSINESS/IN	DUSTRY	WIITTD
(Specify only highest gr. Elementary/Secondary (0-12)	College (1-4 or 5	11fm	Do NOT use	ork done during retired.)	most of worl	king				
12		S	SALESM	IAN			A	PPLIAN	ICES	
Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last)					18. MO	THER'S NA	AME (First, Middle, Ma	iden Sumame)		
SOLOMON		Z	AGER			SAR	AH		SAND	LER
198. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Stre	et and Numb	er or Rural	Route Number, City of	Town, State, 2	(Ip Code)	
PIND. AINIVA	KLEN	OFF	9 E	OLLYW	OD DE	RIVE	PLAINVIE	W. N.Y	. 1	1803
20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20b. PLACE AND DATE OF DATE 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - City or Town, State NEW 20c. LOCATION - CITY 20c. LOCATION - CITY or Town, State NEW 20c. LOCATION - CI										
23. PART 1. Enter the dieeeses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition reculting in death) a. Cardio respiratory arrest, Approximate interval Between Onset end Daath Oue TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events C. DUE TO (OR AS A CONSEQUENCE OF):									
										AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
DID TOBACCO USE CON	TRIBUTE TO CA	AUSE OF DEA	ATH YE	S 🗆 NO	☐ UN	CERTAI	N 🗆			
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	28. PLA	CE OF DEAT	H (Check only	one)					
1 TES 2 NO	1 Inpatient 2	ER/Outpetlant 3	3 🗆 00A	OTHER:	loma 5 🗆	Raaldenca	6 Other (Specify,			
	28a. DATE OF		28b. TIME INJU	URY	INJURY AT WORK? YES 2	□ NO	28d. DEŞCRIBE H	OW INJURY O	CCURED	
2 Accident Investigation 3 Suicide 5 Could not be datarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)									er or Rural	Route Number,
one)	YSICIAN: To the best o									a) and manner as stated.
296. SIGNATURE AND TITLE OF CERTI	tal M			29c. LICENSE NUMBER 29d. DATE SIGNED (Morth, Day, Year) MO 46398 NOV. 13th, 1995						
30. NAME AND ADDRESS OF PERSON										
G. GUPTA, M.D.	c/o MONT	GOMERY (GEN.	HOSP.	OLNE	Y, M	D			

may be retained by the hospital or attending physician,	r, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		st be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	RTMENT OF	HEALTH AND	MENT	AL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last	0					E OF DEATH			3. TIME OF DEAT	Н	
	RUTH AIDYL ADAM	S				Nov	ember 1		995	2:12	рм	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH oth, Day, Year)		Country	PLACE (State or For	reign	
	216-07-2898	1 M 2 X F 7	9 YRS.			OCT	.27,19	16		TIMORE		
œ	9e. FACILITY NAME (If not institution, give				OR LOCATION OF D	DEATH		9c. COUNT				
DIRECTOR	STELLA MARIS HOS	PICE		TOWSO	N			BAL	TIM	ORE		
3EC	10e. STATE 10b. COUN	TY	10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY				
		BALTIMORE	BA	ALTIMORE						LIMITS?	NO	
3AL	10e. STREET AND NUMBER			10	1. ZIP CODE			10g. CITIZE	N OF W	HAT COUNTRY?		
FUNERAL	1706 SUMMIT AVEN				21227				J.S.	Α.		
F	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 NO	It yes, s	CENDENT OF HISPA secify Cuban, Mexic	an, Puert	ilN? (Specify Yes o Rican, etc.)	or No- 1	4. RACE Black	- American India, White, etc.	ın,	
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES A	1 🗆 YE	3 2 XNO Spec	lfy:		1	Specif	y: WHIT	E	
	15. DECEDENT'S ED (Specify only highest grad	(UCATION	16a. DECEDENT'S	USUAL OCCUPATI	ON	10	Bb. KIND OF BUS	SINESS/INDU	STRY	***************************************		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)	ost or wonling							
COMPLET	12TH GRADE		HOM	IEMAKER				OMEMAK	LING			
8	17. FATHER'S NAME (First, Middle, Last) RALPH BROWN				LIDYA C		, Middle, Malden	Surname)				
8			10h MAII ING	ADDRESS (Ottoor								
2	19a. INFORMANT'S NAME (Type/Print) MRS. F. DAWN ADAMS HALL 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5513 DOLORES AVENUE - ARBUTUS, MD. 21227											
	20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITION (N		7		CATION - CI	_			
	1 X Surial 2 Cremation 3 Red 4 Donation 5 Other (Specify)		metery, cremetory or o OUDON PAF	ther place) RK CEMET	ERY	11/		LTIMOF		.,		
	21. SIGNATURE DE FUNERAL SERVICE E	CONSÉE)		22. NAME A	ND ADDRESS OF F	ACILITY		10				
	Y Janie C.	Smill	/		RD FUNER WILKENS				7 M	D 212	20	
	23. PART I. Enter the diseases, or	complications that cause List only one cause on	d the deeth. Do r	not enter the me	da of dying, su	ch as ce	rdiac or respin	ratory arres	st,	Approxima	ite	
	IMMEDIATE CAUSE (Finel	. List only one ceuse on	secn line.							Interval Ba Onset and		
	disease or condition a. Colon (anal)										ears	
	DUE TO (OR AS A CONSEQUENCE OF):											
<u>0</u>	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
\ E	if any, leading to immediate cause. Enter UNDERLYING C											
Ē	thet initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):								
CERTIFICATION	resulting in death) LAST	resulting in death) LAST										
	PART ii. Other significent condition	ons contributing to deeth	but not resulting i	in the underlyin	g ceuse given in	Part i.	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FIN	DINGS	
S					-511		PERFOR	lt at		AVAILABLE PRIOR T	TO	
MEC							T TES 2	Xmo		OF DEATH?		
Ä.	DID TOBACCO USE CON	TRIBUTE TO CAUSE S	OF DEATH YE	S I NO	UNCERTAI	N 🗆				X		
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL. EXAMINER?	HOSPITAL:	28. PLACE OF DEAT	H (Check only size) OTHER:								
KSI	1 YES 2 NO 27. MANNER OF DEATH	1 Inpetion 2 IT/Out	-	4 - Nursing Hon	e 5 🗆 Residence	-	77	0001				
	Natural 5 Pending	28s. DATE OF INJURY (Month, Det. Mer)	396. TIM	URY WO	URY AT HRK7 YES 2 NO	28d. Di	ESCRIBE HOW IN	JURY OCCU	RED			
B	3 Solider Investigation	20s. PLACE OF INJUST	- At home, farm, a		-	281 1.0	CATION (Street a	ad Number or	Dural D	nuto Alumbar		
COMPLETED	4 Homicide determined	butteling, étc. /Sub	CONT.	- X		Cit	y or Town, State)		110/8/ 710	oute Number,	- 1	
ا ڌ	29s. CERTIFIER CERTIFYING PHYS	SICIAN: To the best of my know	riadra, daeth occurr	ed at the time, date	and place, and du	lo the e		Siene Gardia				
MC	one) 2 MEDICAL EXAMIN	IER: On the tiests of exemplestic	on and/or invitaligation	n, in my opinion, o	eeth occured at the	time, da	te and place, and	due to the o	cause(s)	and manner as str	ited.	
	29b. SIGNATURE AND TITLE OF CERTIFIE				29 LICENSE NU		,			Month, Day, Year)		
O BE	The second second second second second				11 15	>64		► //				
임	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DI	EATH (ITEM 27) (Type,		0110.017	m 0:	201				$\overline{}$	
	DR. EDDIE NAKHUDA			ı KD. T	OWSON, N	ய 2]	1204					
	31. DATE 5149 (Month 7 1995	32 REGISTRAR'S S	ATURE									



Approximate interval Between **Onaet and Death**

2.5HOURS

11:20 am »

REG. NO.

ARYLAND 21215-0020	ed by the hospital or attending physici
MA	retain
MORE, MAF	may be
MO	Page 6
PALL	Br darfn.
٤	Diam'r.
6876	xecuted within 24
. BOX 6876	ficate be e
RDS, P.O.	at the death certificate be
RDS	at the

DIVISION OF VITAL RECORDS, P.O. BOX 6876

	1. DECEDENT'S NAME (First, Middle,	Last)							2. DATE OF	DEATH	Y YE	AR 3	TIME OF DEATH					
	CHARLOTTE	BURNS		BA	CA				N	0V 8			11:20 am					
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In	yrs. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF 8 (Month, Da		8.	BIRTHPL Country)	ACE (State or Foreign					
1	212-10-9364	1 M 2 X F	77	YRS.	MONTHS	4/:							LAND					
	9a. FACILITY NAME (If not institution,	give street end number)			9b. CITY,	TOWN C	R LOCATIO	ON OF DEA	TH		9c. COUNTY	OF DEA	тн					
СТОВ	Saint Joseph	Medical Cent	ter			To	NBOR,	Mary	rland		Ba	altimo	ore					
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									Τ.								
DIRE	DESCRIPTION DESCRIPTION OF THE PERSON OF THE	DALMIMODE								tod. INSIDE CITY LIMITS?			LIMITS?					
	MARYLAND 10e, STREET AND NUMBER			10	NSON		_	THE CONTRACTOR				YES 2 NO						
FUNEHAL						101	. ZIP CODI				10g. CITIZEN		AT COUNTRY?					
Ž	1500 GLEN KEITH BLVD. 21286 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No)										SA							
	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES?	1 YES	2 X NO	1	t yee, sp	ecity Cube		ORIGIN? (S Puerto Rice		or No 14.	Black, Specify:	- American Indian, White, etc. WHITE					
3	15. DECEDENT' (Specify only highes	18e. DECEDENT'S	S USUAL O	CUPATIO	ON of working		16b. KIP	D OF BUS	INESS/INDUS	rry								
	Elementary/Secondery (0-12)	ille. Do NOT	use retired.)	idning mo	at the Workin	Y												
	10th GRADE	SHOP C	CLERK				BLA	CK &	DECKE	IR .								
T I	17. FATHER'S NAME (First, Middle, La			18. MOT	HER'S NAM	E (First, Midd	le, Meiden S	Sumeme)		10.7								
ı	SAMUEL BURNS					MARY	ALLIS	SON										
	19e. INFORMANT'S NAME (Type/Print		19b. MAILIN	G ADDRESS	(Street e	nd Number	r or Rural Ro	oute Number,	City or Town	, Stete, Zip Co	de)							
	LOUIS B. BACA			1500	GLEN	KEI	TH B	LVD.	TOWS	ON,	, MD 21286							
ł	20a. METHOD OF DISPOSITION 1X Buriet 2 Cremetion 3	DDATE OF DISPOSITION (Name of tory or other place)						or Town	n, Stata									
	4 Donetion 5 Other (Specify)		RKWOOD.		TERY	r	11	/11/9	5 B	ALTIMO	RE,	MARYLAND					
	21. SIGNATURE OF FUNERAL SERV	ME LICENSES						SS OF FACE		TET			The Park of					
	JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON,								I, M	D 21286								
	shock, or heer saffure. List only one ceuse on each line.										Approximate interval Between							
1	IMMEDIATE CAUSE (Final disease or condition										Onaet and Dea							
	resulting in daeth) a. RESPIRATORY ANNEST																	
- 11	10 99	DUE	TO (OR AS A	CONSEQUENCE (OE):				CHRONIC OBSTRUCTIVE PULMONARY DISEASE									
2	1		-		,	PLILI	MONA	LRY DE	SEASE	1								
N C	Sequentially list conditions,	CHE	IONIC		CTIVE	PULI	MONA	VRY DI	SEASE			_						
CATION	if any, leading to immediate cause. Enter UNDERLYING	CHE	IONIC	OBSTRUC	CTIVE	PULI	MONA	VRY DI	SEASE									
FICATION	if any, leading to immediate	DUE C.	TO (OR AS A	OBSTRUC	CTIVE	PULI	MONA	VRY DI	SEASE									
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	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa	b. CHR DUE c. DUE d	TO (OR AS A	OBSTRUC CONSEQUENCE (OF):					a. WAS AN		1	WAILABLE PRIOR TO					
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FRANCIS KHOO, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204

31_DATE FILED (Month, Day, Year) NOV1 71995

FOR STATE REGISTRAR



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STATE STATE OF THE PARTY OF THE

Page 6 may be retained by the hospital or attending physician. **MORE, MARYLAND 21215-0020** BOX 6876 executed HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be DIVISION OF VITAL RECORDS, P.O.

page 5 should be detached director, funeral (the filled burial. and prior to the attending physical difference of Health a has been signe Dept. of Healtl n 23 shows a certificate to the State 1, or item this ce with t After DIRECTOR: A

Pages 1, 2, 3 should

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TO THE HOSPITAL
TO THE FUNERAL E
Be filed within 72 h
IMPORTANT: If II

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH November 15,1995 FRANK JOSEPH BOGDAN 7:10 P. M 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 219 01 5243 DAYS HOURS 07 23 18 Maryland 1 X M 2 - F 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Horizon Nursing Home Baltimore N/A DIRECTOR RESIDENCE OF DECEDENT 10d. INSIDE CITY

LIMITS?

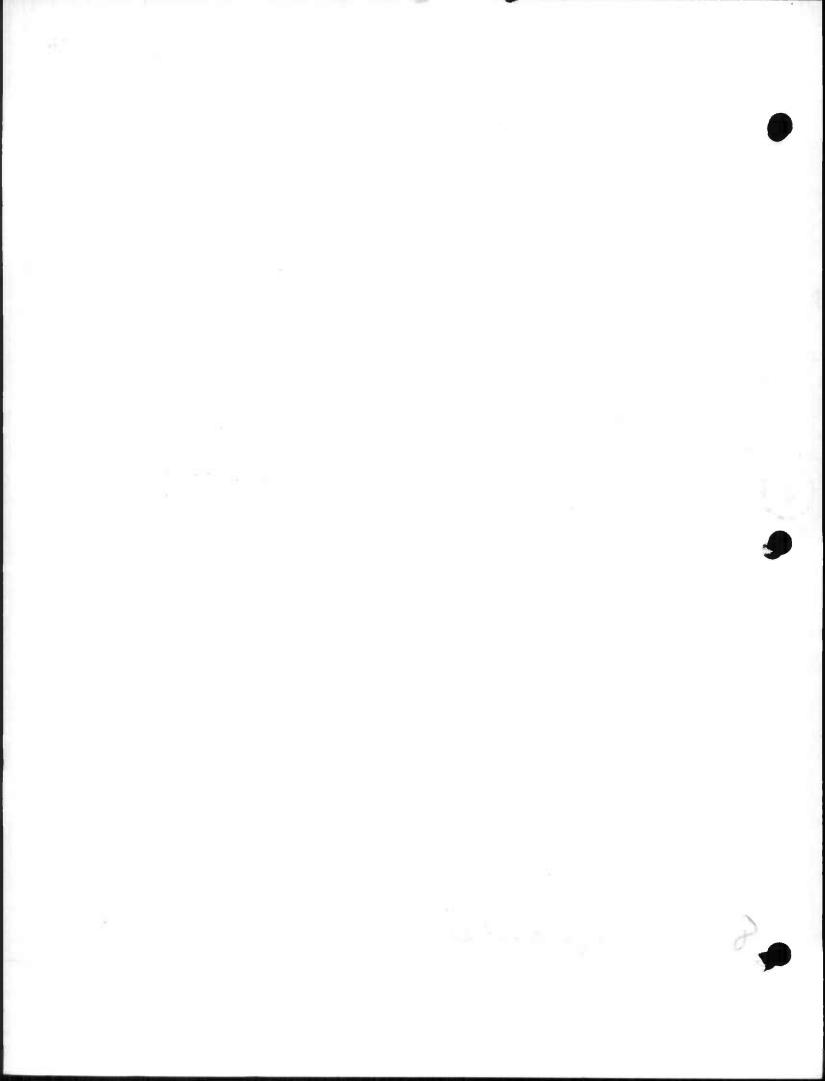
TEL YES 2 NO 10b. COUNTY 10c. CITY, TOWN OR LOCATION Md. N/A Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3029 Hudson Street 21224 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. Il yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1 Never Merried 2 N Merried Specify: BY 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5 +) Aerospace Painter COMPL Unknown 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumerne)
Julia Machlinski Frank Boodan 19e. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3029 Hudson Street Balto., Md. 21224 Marian L.Bogdan 20e. METHOD OF DISPOSITION DATE 20c. LOCATION - City or Town, State 20b PLACE AND DATE OF DISPOSITION /Name of 20e. METHOD OF DISPOSITION

1 Serial 2 Cremation 3 Removal from State

4 Donetion 5 Other (Specify) Meadowridge Memorial Park 11-17-95 Elkridge,Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 901 S. Conkling St. Balto., Md. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter tha mode of dying, such se cardiec or respiratory arrest, Approximate ahock, or heart feilura. List only one ceusa on each line. intervel Between Onset and Daath IMMEDIATE CAUSE (Fine) disease or condition numbers reaulting in death) DUE TO (OR AS A CONSEQUENCE OF)-CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Esoplagon 6 mo CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗗 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL OTHER:
Nursing Home 5 Reeldence 6 Other (Specify) HOSPITAL: 1 | YES 2 YOU 1 | Inpetient 2 | ER/Outpetient 3 | DOA 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town State) COMPLETED 4 Homicide 29e. CERTIFIER
(Check only one)

The Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(e) and menner se stated. 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER **BE** 24276 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



TO BE COMPLETED BY FUNERAL

Iet	tm#17. G-fi for 1-STATE REGISTRAR	ilm 72	29 per STATE OF I	
	1. DECEDENT'S NAME (First		TENKO	
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.
	216-30-9264		1 M 2 XX	76
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)	
DIRECTOR	Church H		spital	
5	RESIDENCE OF DEC			
삤	10e. STATE	10b. COUNTY		
ā	Md.	N/	Α	

1/17/95 P.C D/DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERT	IFICATE	OF L	DEATH	F	REG. NO.			
1. DECEDENT'S NAME (First, Middle, Lest) MARIA BUT	enko					2. DATE OF MONTH	DEATH DAY	190	RAS	TIME OF DEATH 512 PM M
	5. SEX 6.	AGE (In yrs. lest birthdi 76 YRS	MONTHS		IF UNDER 24 HRS.	7. DATE OF (Month, De 03-25	BIRTH by. Year) -191	9 I	BIRTHPLA Country) Krai	CE (State or Foreign
9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY,	TOWN OR	LOCATION OF DE			9c. COUNTY	OF DEAT	н
Church Home Hos	spital			Bal	timore			N/A		
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c.	CITY, TOWN OF	R LOCATIO	N				104	1. INSIDE CITY
Md. N/A	1		Baltin		Tec				13	LIMITS? XYES 2 NO
625 S. Montford	l Avenue				21224				S.A.	COUNTRY?
11. MARKTAL STATUS 1 Never Merried 2 Married XX Widowed 4 Divorced	12. WAS DECEDENT EX FORCES? 1 I	YES XX NO	- 17	yes, speci	IDENT OF HISPAN ify Cuben, Maxicar XXO Specify	n, Puerto Rica			RACE — Block, W Specify: Thite	American Indian, hite, atc.
15. DECEDENT'S EDUCA		16a. DECEDEN	T'S USUAL OC	CUPATION		16b. Kil	D OF BUSI	NESS/INDUS		:
(Specify only highest grade of Elementery/Secondary (0-12)	College (1-4 or 5+)	(Give kind life. Do NO	of work done do T use retired.)	uring most	of working					
12		Domest	tic			Haus	ssner	's Res	staur	ant
17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NAI		lle, Maiden S	lumeme)		
Unknown P. NAZ	ARENKO				Unknown					
Wesley Butenko				,	Number or Rural F l Drive,		. ,	2122		
20a. METHOD OF DISPOSITION 1XXBurlal 2 Cremation 3 Remov 4 Donation 6 Other (Specify)	ral from State	20b.PLACEAND DA cemetery, cremetory St. Andre	TEOF DISPOSITION OF Other place!	TION (Name		18/95		timore		
21. SIGNATURE OF PUNERAL SEMPECE LICE	MSEE /	1			ADDRESS OF FAC			212		
- Allen	94		Lil	11y 8	Zeiler	Inc.	1901			lvenue
23. PART I. Enter the diseases, or co ahock, or heart feiture. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	mplications that collection only one cause	on each line.								Approximate interval Between Onset and Death
	CULUMA DUE TO (OR	AS A CONSEQUENC	E OF):							YEVANS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	mon	AS A CONSEQUENCE	MUTIC	cn	NDIWA.	sul	gr o	0154	OST	Yeuns
0.										
PART II. Other aignificant conditions	contributing to de	ath but not reauiti	ng in the und	derlying	cause given in		PERFORI	MED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
				~ /					1	YES 2 NO
DID TOBACCO USE CONTR	BUTE TO CAUS			10, X	UNCERTAIN	4 🗆 📗				
	HOSPITAL:	26. PLACE OF I	OTHER	l;						
1 YES 2 NO	26a. DATE OF INJ			ing Home 28c, INJUI	5 Residenca			JURY OCCUP	ED	
Netural 5 Pending Investigation	(Month, Day,		INJURY M	WOR	K? ^\ S 2 □ NO	Zeo. DESCH	IBE HOW IN	JOHT OCCUP	IED .	
3 Suicide 6 Could not be detarmined	26e. PLACE OF III building, atc.	NJURY — At home, far . (Specify)	rm, street, facto	ory, office			ON (Street a fown, State)	nd Number or	Rural Rout	e Number,
29a. CERTIFIER (Check only one) CERTIFYING PHYSIC DESCRIPTION ON DESCRIPTION OF THE CERTIFYING PHYSIC DESCRIPTION OF THE CERTIFICATION	IAN: To the best of my									nd manner es stated.
295 MONATURE AND TITLE OF CERTIFIER	AMANI	M			29c. LICENSE NUN	MBER 35				onth, Day, Year)
IN NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM 27)	Type, Print)		וטוע	03		700	1)	MAIS
31. DATE FILED (Month, Day, Year)	OS) MA	SIGNATURE							····	
NOV 17 1995 g	up attender	Ravfall								

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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Q	BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2.4 hours after death. Page 6 may be retained by the hospital or attending physician.	3 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2. 3 should if the within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nedical examiner must be notified at once.
•	DIVISION OF VITAL RECORDS, P.O. BOX 68760	IAN: The law requires that the death certificate be executed within 24 h	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the : be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	DIVISION OF	TO THE HOSPITAL OR ATTENDING PHYSICIA	TO THE FUNERAL DIRECTOR: After this cert be filed within 72 hours after death with the	IMPORTANT: if item 28 is marked, or

	1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	VIOLA ISABELLE BA	СН				NOVEMBER		YEAR	
	4. SOCIAL SECURITY NUMBER 5	. SEX 6. AGE (H	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		B. BIRTHPLACE (State or Foreign	
		□ M 2 🖾 F 92	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) JAN . 6 , 1903	3	Country) BALTO CITY	
	9a. FACILITY NAME (If not institution, give stree			9b. CITY, TOWN C	R LOCATION OF D			TY OF DEATH	
E	MANOR CARE NURSING	CENTER (F	RUXTON)	TOWS	ON		BA	LTIMORE	
띦	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY	
DIRECTOR	MARYLAND BALT	TIMORE			IMORE			LIMITS?	
AL	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?	
FUNERAL	4106 LEEDS AVENUE				212	29		S.A.	
5	11. MARITAL STATUS 12	2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Yes		4. RACE American Indian	
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO Specific	n, Puerto Rican, etc.)	Black, White, etc. Specify:				
	15. DECEDENT'S EDUCAT	T. T.						WHITE	
COMPLETED	(Specify only highest grade con	npleted)	(Give kind of w life. Do NOT use	ork done durina ma	N st of working	16b. KIND OF BUS	SINESS/INDU:	STRY	
P	H/S GRADUATE	College (1-4 or 5+)		CRETARY		STATE	OFM	ARYLAND	
O.	17. FATHER'S NAME (First, Middle, Last)			711211112	18, MOTHER'S NA	ME (First, Middle, Maiden		AKILAND	
ш	WILLIAM P. BACH					ANE HARRIS			
0 8	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural	Route Number, City or Tow	n, State, Zip C	TOWSON, MD2120	
F	MAXWELL R. COLLINS	s, II	LAFAYE	TTE BLD	G40 W.	CHESAPEAKE	AVE.	-SUITE 200	
	20e_METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Remova	1 from State come	PLACE AND DATE O	F DISPOSITION /Na	me of			ty or Town, Stata	
	4 Donation 6 Other (Specify)	S	Ty, crometory of ou	S CEMET	ERY	11/17 AR	CADIA	, MD.	
	21. SIGNATURE OF UNERAL SERVICE LICENS	SEE	1	HUBBA	D ADDRESS OF FA	CLUTY AL HOME IN	C		
	1 Mujul	with	06					E, MD. 21229	
	23. PART I. Enter the diseases, or com shock, or heart fallure. Lis	plications that caused	the death. Do no	ot entar tha mo	de of dying, suc	h aa cardlac or respi	ratory arres	st, Approximata	
	IMMEDIATE CAUSE (Final	t only one causa on es	on line.	56				Interval Between Onset and Death	
	disease or condition resulting in death)								
		DUE TO OR AS A	CONSEQUENCE OF	1001	itur w	2		11/0	
NO	Sequentially list conditions, b	DUE TO (OF AS A	ONSEGUENCE OF	IST CW	my w	CONS		3 year (
TA	If any, leading to immediate cause. Enter UNDERLYING	oge 10 (on as A	SUISEGUENCE OF	1					
트	CAUSE (Disease or injury that initisted events	DUE TO (OR AS A	CONSEQUENCE OF	:					
CERTIFICATION	resulting in death) LAST								
	PART II. Other significant conditions c	ontributing to death bu	t not resulting in	the underlying	sausa shan In	Day 1 00 110 000			
CAL	The state of the s	Ontributing to Death Du	t not reauting in	i the underlying	cause givan in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
EDIC						1 YES 2	NO	OF DEATH?	
2	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	DEATH VE		UNCERTAIN	Total .		1 TYES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		B. PLACE OF DEATH		UNCERIAII	N 10-			
Sic		OSPITAL:	~:	OTHER:	S C Broldens	6 Other (Specify)			
Ŧ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. INJ	JRY AT	26d. OEŞCRIBE HOW II	NJURY OCCU	RED	
ВУ Р	1 Accident Pending	(Month, Day, Year)	INJU		ES 2 KNO				
	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, etc. (Specif	At home, farm, st	reet, factory, office		261. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,	
Ш 4									
COMPLET	29a. CERTIFIER (Check only CERTIFYING PHYSICIAL	N: To the best of my knowle	dge, death occurred	st the time, date	and place, and due	to the cause(a) and man	ner as stated		
OM								cause(a) and menner ea stated.	
ш	286. SIGNATURE AND TITLE OF CENTIFIER	/// //	(M)		29c. LICENSE NUM	IBER	29d. OATE S	BIGNEO (Month, Day, Year)	
w		~ X/	0/0/		D-42736			EMBER 13, 1995	
5	30. HAME AND ADDRESS OF PERSON WHO CO							23, 1773	
	DR. AYMAN AKKAD -	7600 OSLER	DRIVE -S	SUITE #2	03 - TOW	SON, MD 2	1204		
	NOV 1 7 1995 Jalia	22. REGISTRAR'S SIGNAT	URE				VT		
	1101 I 1333 Have	TO STANDARD SANDARD							



TO THE HOSF TO THE FUNE OF FILED WITHIR	the state of the s	TO THE MOSTIAL OR ALTENDING PHYSICIAN: THE Jaw requires that me death certificate be executed with the attending physician. The Fine Ball DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netitled at once.
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									-	10	34001	
	FOR STATE REGISTRAR	STATE OF MA					EALTH AND I	MENTAL HYGIEN				
1	1. DECEDENT'S NAME (First, Middle, Last)	2		-	-			2. DATE OF DEATH	MY	YEAR	3. TIME OF DEATH	
	HELEN M	. BODA	BODNAR						R 11	95	09:12 4	
- 1	4. SOCIAL SECURITY NUMBER		AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign	
	217-01-9832	1 M 2 T F	76	YRS.	MONTHS	DAYS	HOURS MIN.	JULY 29,	1919	MA1	NYLAND	
ļ	9a. FACILITY NAME (If not institution, give stre	7 0		9h CITY	TOWN O	R LOCATION OF DE			UNTY OF D			
æ .	ST. AGNES HOSPITAL					LTIM					RE CITY	
임	RESIDENCE OF DECEDENT				DA.	PITI	OKE		DAL	JI LIIO	KE CIII	
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	R LOCAT	ION			- 1	10d. INSIDE CITY	
E	MARYLAND ANNE	ARUNDEL		L	INTH	ICUM				ŀ	LIMITS?	
	10e. STREET AND NUMBER					106	ZIP CODE		10a. Cl	TIZEN OF V	VHAT COUNTRY?	
FUNERAL	119 SYCAMORE ROAD						21090					
		12. WAS DECEDENT	F1/F0 IN 11 0 AO						U.S.A.			
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WAI	YES 2X N			f yes, spe		n, Puerto Rican, etc.)	a or No—	Black Specif	E — American Indian, c, White, atc. WHITE	
0	15. DECEDENT'S EDUCA	TION	18a, DE	CEDENT'S	USUAL O	CCUPATIO	N	16b. KIND OF BU	ISINESS/IN	IDUSTRY		
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Gi	ive kind of Do NOT u	work done (se retired.)	during mos	st of working	200 2007				
2	8TH GRADE	Conega (I-4 or 5+)	HOM	EMAK	ER			HOME	MAKIN	1G		
NO.	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA	ME (First, Middle, Malder	Sumama)			
	HENRY BRYSON							RANCES WH				
띪	19a. INFORMANT'S NAME (Type/Print)		101	- MAII INC	ADDRESS	7 (Obsert o		Route Number, City or To				
임	MARGARET BODNAR		130					- HANOVE			076	
	20g, METHOD OF DISPOSITION		1									
	1 X Buriel 2 Cremation 3 Remov	ral from State	20b. PLACE / cemetery, cre LAKEV					1		– City or To /ILLE	wn, State	
	4 Donation 5 Other (Specify)	NSEE	LAKEV	TEW.	_	_	I AINN IO ADORESS OF FA		IKEDV	Thre		
i	> M. Neaf	Colon	~/		HU:	BBAR	D FUNERA	L HOME IN		RE, M	D 21229	
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate											
	shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Finel Onset and Death											
	disease or condition	Meta	Metastatic Broast Cancer					,			Venior	
	resulting in death) a.		OR AS A CONSE								years	
_												
CERTIFICATION	Sequentially list conditions, b.	DUE TO (OR AS A CONSE	DUENCE O	F);							
AT	If any, leading to immediate cause. Enter UNDERLYING											
윤	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	DUENCE O	iF):						-	
E	regulting in death) LAST											
	d.											
	PART II. Other significant conditione	contributing to d	leeth but not i	reculting	In the ur	nderlylng	g cause given in	Part I. 24a, WAS A	N AUTOPS	r 24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO COMPLETION OF CAUSE OF DEATH? 248. WERE AUTOPS' PROOF TO COMPLETION TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO UNCERTAIN DID TO COMPLETION OF DEATH OF THE PROOF TO COMPLETION OF CAUSE OF DEATH? 27. MANNER OF DEATH 280. DATE OF INJURY AT WORK? 280. DESCRIBE HOW INJURY OCCURED INJURY WORK?									COMPLETION OF CAUSE			
2	DID TOBACCO USE CONTRI	BUTE TO CAL	ISE OF DEA	TH Y	ES 🗍 I	NO A	UNCERTAIL	NO		1		
AN	25. WAS CASE REFERRED TO MEDICAL				TH (Check	only one)						
200		HOSPITAL:	ER/Outpatient 2	□ pos	OTHE		a & Donklan	& Char (Case)				
×	27. MANNER OF DEATH	28a. DATE OF II		28b. TIR		28c. INJ		6 Other (Specify) 28d, DESCRIBE HOW	INJURY O	CCURED		
	1 Natural 5 Pending	(Month, Day			JURY	WO	RK?					
B	2 Accident Investigation	284 DI ACE OF	INJURY — At ho	me form	stead for			28f. LOCATION (Stree	and thusb	ner or Dure!	Poude Number	
	3 Suicide 8 Could not be 4 Homicide determined	building, a	te. (Specify)	mie, rarm,	attent, tac	tory, Offic		City or Town, State		en or Mural I	voice Hallinon,	
COMPLETED												
립	CONSCA ONLY	IAN: To the best of m	ny knowledge, de	eth occur	red at the t	lime, data	and place, and due	to the cause(a) and m	enner de si	tated.		
0	one) 2 MEDICAL EXAMINER	: On the basis of exe	amination and/or	investigati	on, In my	opinion, d	eath occured at the	time, data and place,	and due to	the cause(r	a) and manner as stated.	
	296 AUGUNTURE AND TOLE OF CERTIFIER						29c. LICENSE NU	MBER	29d. D/	ATE SIGNED	(Month, Day, Year)	
H	Bun Herer	_					DRas	42	1	Vovemi	ber 15,1995	
2	30. NAME AND AGORESS OF PRODUCTION WHO COMPLETED CAUSE OF OFATH (ITEM 27) (Types Print)											

O COMPLETEO CAUSE OF OEATH (ITEM 27) (Typo, Print)
S MA) GOO CATON AVONUE

1 32 DEGIS TAR'S NA PRI SCRUGIAS

BAZTIMORE, MARYLAW)

21229

1 . .

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hydrene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEOISTHAN				CENTIF	ICALE	OF L	JEAI	П		reg. No.			
	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
1		John	W. Barn	ahv						MONTH	15		YEAR	
								NOV.		1993		10:35 P M		
	F-100				Mana	-	-	HOURS	MIN,	(Month, D			II. BIRTI	HPLACE (State or Foreign ry)
	218-10-2448		1 M 2 F	89	YRS.					Dec 2	4. 1	905	Mar	ryland
	90. FACILITY NAME (If not in	stitution, give st	treet end number)			9b. CITY, 1	OWN OR	LOCATION					NTY OF E	
DIRECTOR	830 ti	10+h C+	twoot			р.	142					37/		
1 5	830 W. A	EDENT	Teer			Di	ILLI	more				N/A	4	
Ĭ Ĭ	10a. STATE	10b. COUNTY	,		10c. CI	Y, TOWN OR	LOCATIO	DN					_	10d. INSIDE CITY
	Maryland	N/A	A			Baltin	nore							LIMITS?
3 1	10a. STREET AND NUMBER						1							1 X YES 2 NO
A A							101. 2	ZIP CODE				10g. CIT	IZEN OF	WHAT COUNTRY?
買	830 W. 4d	oth Sti	reet					2	1211			J	J.S.	Α.
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN			13. W	S DECEN	DENT OF	HISPANI	C ORIGIN? (S	Specify Yes	or No-	14. RAC	E — American Indian,
1 1	1 Never Merried 2 7	Merried	FORCES? 1 IF YES, GIVE W	AR OR DATE	S INO			Ify Cuben,		, Puerto Rica	n, etc.)		Spec	k, White, etc.
ВУ	3 Widowed 4 Divo	rced						27.10	opoury.				Spec	White
COMPLETED	15. DEC	EDENT'S EDUC	CATION	16	e. DECEDENT'S	USUAL OCC	UPATION			16b, KII	ND OF BUS	INESS/INI	DUSTRY	
ᇤ	Elementary/Secondary (I	y highest grade	College (1-4 or 5+		(Give kind of life. Do NOT u	work done du se retired.)	ring most	of working						
4	12	-12)	5+		Physic	ian				Me	dica:	1		
Σ	17. FATHER'S NAME (First, M	7.4.46 4 4			1117010									
8							1			AE (First, Midd				**
出	John W. I		7							ne R.	0.			
0	190. INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADDRESS (Street and	Number o	r Rural A	oute Number,	City or Town	n, State, Zip	Code)	
=	Geraldine	Cole			694 E	udlei	gh C	Circl	e,	Timon	ium,	Mary	land	21093
	20e. METHOD OF DISPOSIT	ION		20h PI	ACE AND DATE					DATE				own, State
	1 Buriel 2 XCrematic	n 3 🗆 Remo	oval from State	cemeter	ry, crematory or c	ther place)	ON INAME	901	11/1	O /OE	200, 100	ATION —	City or 10	Maryland
	21. SIGNATURE OF FUNERA			Jure	en Mou						Bal	timoi	re, r	laryland
	21. SIGNATORE OF FUNERA	11	1	10				ADDRESS		Jr.	Funo	ma 1 I	Jama	
	> M. K	llas	Seit	·										
	23 PART I Enter the di		omplications that		- 4 - 11 - 12	38.	18 R	olan	d Av	re, Ba	1t1mc	ore,	Mary	yland 21211
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between													
	IMMEDIATE CAUSE (Final Onset and Deat										Onset and Death			
	disesse or condition resulting in death)									150				
	DUE TO (OR AS A CONSEQUENCE OF):													
_	- COFD 20 m										20 mm			
CERTIFICATION	Sequentially list conditions,													
A	If any, leading to immediate. Enter UNDERLY	diate NG				,.								
유미	CAUSE (Disease or inju		Dure TO	00 40 4 00	NCEOUENCE O									
	that initiated events resulting in death) LAS		DUE 10 (OH AS A CO	NSEQUENCE O	r):								
H	reconning in death, EAS							¥						
	PART II Other significa	nt condition	a contribution to	double have	not and date		4.1							
EDICAL	PART ii. Other significa	condition	_ contributing to	uesin OUI I	not reaulting	in the unde	riying o	suae giv	ren in P	rart i. 24	PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
용		- pr								1	YES 2	1		COMPLETION OF CAUSE
											4			OF DEATH?
2	DID TOBACCO U	SE CONTE	IRLITE TO CAL	ISE OF I	JEATH VI	C P AL		LINICE	DTAIL					1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO		IDOIL TO CA		_			UNCE	KIAIN					
$\overline{\mathbf{c}}$	EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF DEA	OTHER:	y one)							
Z S	1 TES 2 NO		1 🗆 Inpatient 2 🗆	ER/Outpetie	nt 3 🗆 DOA		g Home	5 🗌 Resid	dence 8	Other (Sp	pecify)			
표	27. MANNER OF DEATH		28e. DATE OF I		28b. TIM	E OF 20	C. INJUR			28d. DESCRI	BE HOW IN	JURY OC	CURED	
ВУ		Pending nvestigation		_	-		1 YES		NO	***************************************				
	2 Suitelde		28e. PLACE OF	INJURY -	At home, lerm,	street, factors	, office			28I, LOCATIO	N (Street a	nd Number	or Burel F	Poute Number
Ш	_ " _ "	Could not be determined	building, a	rtc. (Specify)		**************************************				City or To	wn, State)	TO TTOTAL	01 1101011	note realizati,
<u> </u>	AA- AFRICATIO													
COMPLETED			SIAN: To the best of a											
8) and menner se stated,
One) 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the control of the control														
										4		N 1.4		100
	Tacilla Pillipart									61		192		
8	Gregor	1 3.	VI X 1281	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
														112
BE	30. NAME AND ADDRESS OF Gregory W						et			re, Ma	aryla		1218	3
BE	Gregory W	alker,	MD. 333	3 N. (Calvert		et				aryla		1218	1 12
BE		alker,	MD. 333		Calvert		et				aryla		1218	3

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law mounts that the death certificate has been signed by the inventor be secured within 21 his confidence of the confidence has been signed by the attending projection and comparison and

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPARTMENT OF		MENTAL HYGI					
1	1. DECEDENT'S NAME (First, Middle, Last)	n CLOUD	F		2. DATE OF DEATH	DAY	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. In		EAR IF UNDER 24 HRS.	7. DATE OF BIRTH	4 199	75 11-30 P M			
	213-07-33 04	1 M 2 G F 73	YRS. MONTHS D	AYS HOURS MIN.	05-22	-22	Country) NC			
TOR	CHURCH HOME HOSPITALBALTO.									
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
	10e. STREET AND NUMBER	VA	Balt	D.			1 X YES 2 NO			
FUNERAL	1514 Abbot	tston St.		101. ZIP CODE	8	10g. CITIZE	N OF WHAT COUNTRY?			
	11. MARITAL STATUS 1 X Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2	NO If yo	DECENDENT OF NISPA a, specify Cuban, Maxic	en, Puerto Rican, atc.	Yea or No — 14	l. RACE — American Indian, Black, White, atc.			
D BY	3 Widowed 4 Divorced	IF YES, OIVE WAR OR DATES		YES 2 🔀 NO Specif			Specify: Black			
ETE	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	completed) (C	ECEDENT'S USUAL OCCU Give kind of work done during b. Do NOT use retired.)	PATION og most of working	16b. KIND OF	BUSINESS/INDUS	STRY ()			
COMPLETED	12th	NA	Never	Work	d Ne	Ver 1	Worked			
	17. FATNER'S NAME (First, Middle, Last) Hamphon	CLOUDE		18. MOTHER'S NA	ME (First, Middle, Mail F B 1	den Surname)	Carkle			
TO BE	19a. INFORMANT'S NAME (Type/Print)	h 2 2 2 4 19	b. MAILING ADDRESS (St	reet and Number or Rural	Route Number, City or	Town, State, Zip Co	ode)			
	20a, METNOD OF DISPOSITION	herson 1	AND DATE OF DISPOSITION	botts+	DATE 200	13 G 1+0	y or Town, State			
	1 X Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State cemetery, cre	emetory or other plece)	Cem.	18.99	Batto	. M.D			
	21. SIGNATURE OF FUNERAL SERVICE LICE	MEET.	- Be	H S FU	peral 1	tome	1			
\dashv	23. PART I Enter the diseases, or co	MADELLE CONTROL OF TH	1/2	9 N. Car	olines	+ B9	HO, MD 21213			
	shock, or treat failure. L IMMEDIATE CAUSE (Final disease or condition resulting in death)	list only one cause on each line	LATION			spiratory arres	Approximate Interval Between Onset and Death			
	DUE TO (OR AS A COMSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	If any, leading to immediate								
FICA	CAUSE (Disease or Injury	DUE TO (OR AS A CONSE	OUENCE OFF							
ERT	that initiated events resulting in death) LAST									
AL C	PART II. Other significant conditions	contributing to death but not	resulting in the under	lying cause given in		AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
EDICA	CVA, H	purtension			1000000	2 XNO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
2	DID TOBACCO USE CONTR	IDUITE TO CAUSE OF DEA	THE VEC TO NO	- III III III III III III III III III I		(-	1 TYES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLAC	CE OF DEATH (Check only		NAI					
YSIC	1 TYES 2 NO	HOSPITAL: 1 A Inpatient 2 ER/Outpatient 3	OTHER:	Nome 5 - Residence	6 Other (Specify)					
	27. MANNER OF DEATH 1 Netural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	INJURY	WORK?	28d. DESCRIBE HO	W INJURY OCCUP	RED			
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At ho building, etc. (Specify)			281. LOCATION (Street and Number or Rural Route Num City or Town, State)		Rural Route Number,			
LETE										
COMPLET	(Check only	HAN: To the best of my knowledge, de On the basis of examination and/or	eath occurred at the lime, investigation, in my opinion	date end place, and due on, death occured at the	to the cause(a) end time, date and place	menner as stated.	euse(s) end manner as stated.			
E C	296. SIGNATURE AND TUTLE-OF CENTURES	29d. DATE S	IGNED (Month, Day, Year)							
2	30. NAME AND ADDRESS OF PERSON WHO DROCHANEY	COMPLETED CAUSE OF DEATH (ITE	M 27) (Type Print)	121-4	0521	► N2	v. 14,1995			
	DR OCHANEY	CHURCH	HOS PITA	SALTIMO,	SOLTH B	212	31			
	31. DATE FILED (Month, Day, Year) NOV1 71995	32. DEGISTRAR'S SIGNATURE								

3601

V-0-

DIRECTOR

FUNERAL

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CERTIFICATION

PHYSICIAN:

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DIRECTOR: After the hours after death volume 18 is mark

TO THE HOSPITAL OF THE FUNERAL COME FILED WITHIN 72 HOUSE MADERIANT: If II

TIMORE, MARYLAND 21215-0020

BOX 6876

P.O.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

certificate has been the State Dept. of

DIVISION OF VITAL RECORDS,

the attending physician Mental Hygiene prior to and t апу signed b

Item#20.b. G-film 729 per FH. 11/17/95 P.C

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN MICHAEL EDWARD CONDON OVEMBER 1994 8:50 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 6. BIRTHPLACE (State or Foreign DAYa HOURS 1 M 2 | F YRS. 219-70-1120 39 FEB. 24, 1956 MINNEAPOLIS.MN. 9a. FACILITY NAME (If not institution, give street and number 95 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE CITY 2933 GUILFORD AVE BALTIMORE CITY 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY BALTIMORE 1X YES 2 NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2933 GUILFORD AVENUE 21218 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify: Specify: WHITE 3 Widowed 4 X Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade comple. 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE CHIEF RESTAURANT 17, FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) THOMAS CONDON SANTINA LELLI 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SUMMIT HILL COURT - B-4 - CATONSVILLE, MD 21228 MRS. SANTINA CONDON CEM_11/17 20a, METNOD OF DISPOSITION
1 XSurial 2 Cremation 3 Removal from State 20b. PLACE NEW CATHEDERAL CEMETERY 20c. LOCATION — City or Town, Stata BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HOME, INC. ar 00 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abock, or heart failure. List only one cause on each line. Approximate interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition Meumonia reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO alcoholism COMPLETION OF CAUSE OF DEATH? 1 KES 2 NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN ME 26. PLACE OF DEATN (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL 1X YES 2 NO Inpetiant 2 - ER/Outpetient 3 - DOA 4 - Nursing Nome 5 Residence 6 - Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 27. MANNER OF DEATH 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Nomicide 29a. CERTIFIER (Chack ank) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 💢 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) O.C.M.E. NOVEMBER 13,1995 Jums druste 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

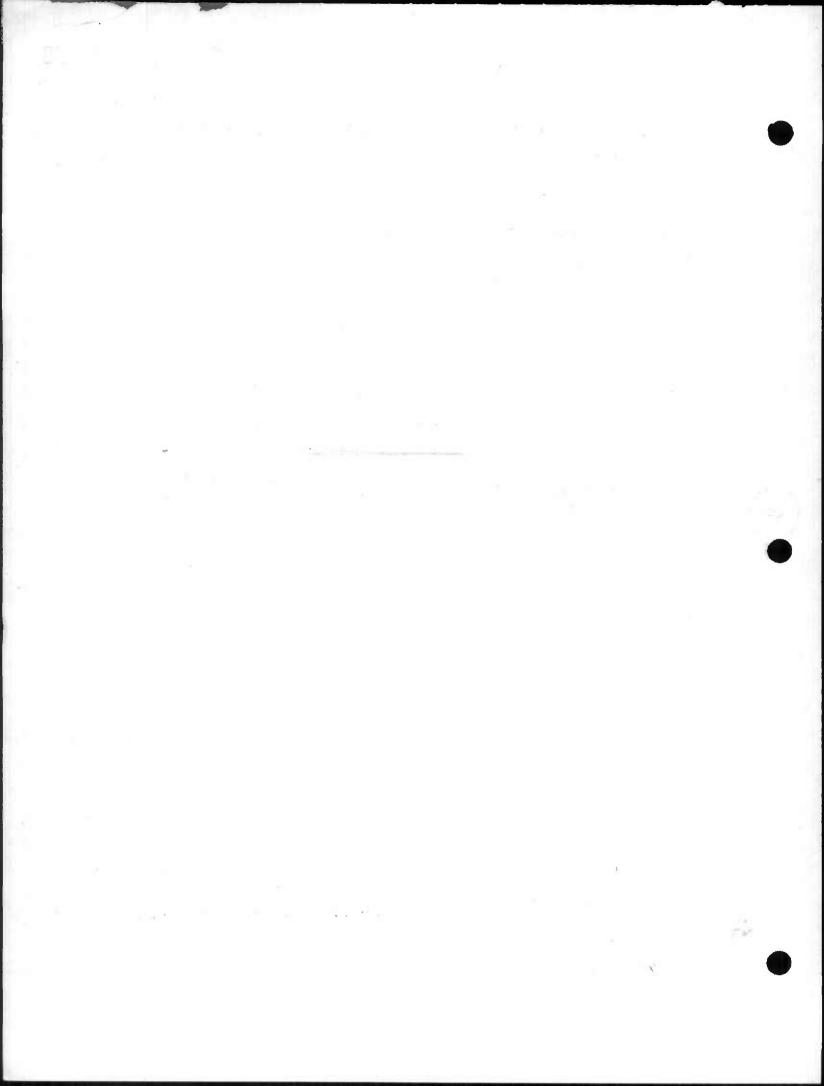
32 REGISTRAR'S SIGNATURE

DR. DENNIS J. CHUTE

31 DATE FILED (Month Day Year)

NOV 1 7 1995

111 Penn Street, Baltimore, Maryland 21201

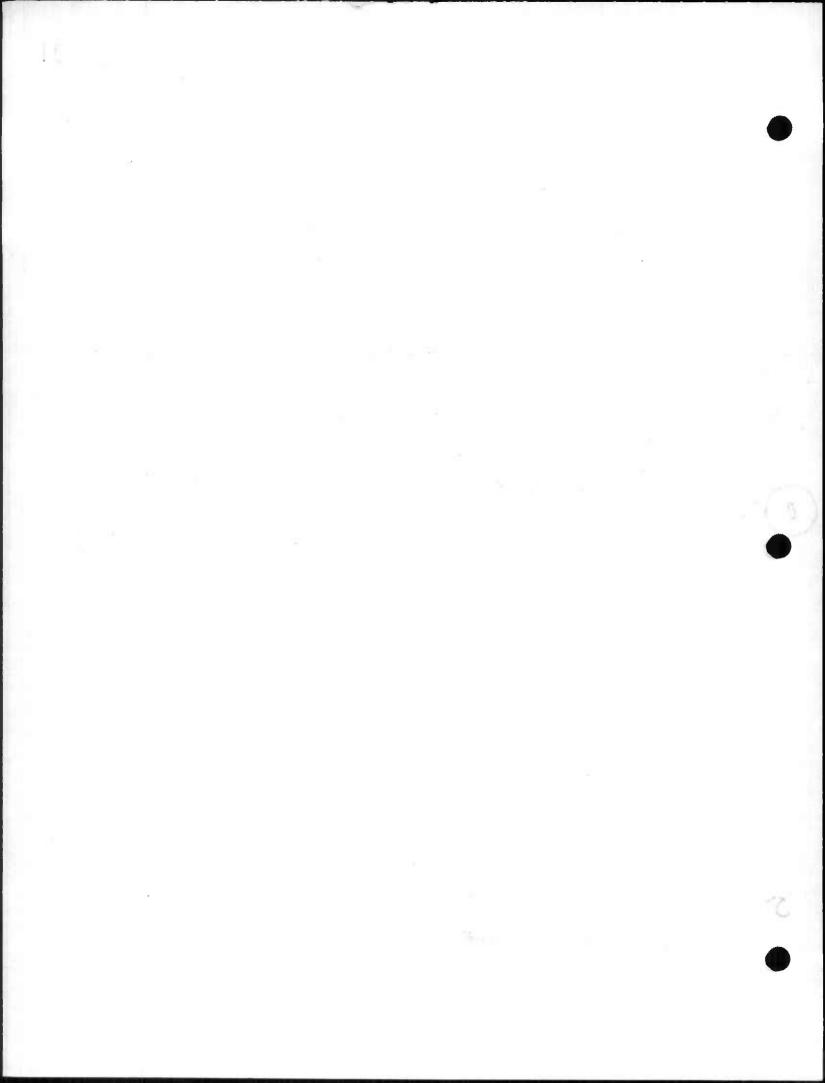


LTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the local continuous of the hospital or attending physician.
TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-tran
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year) NOV 1 7 1995

							9	3 34031	
	1 - STATE REGISTRAR	STATE OF MARYLAI			HEALTH AND I	MENTAL HYGI Reg. 1			
	1. DECEDENT'S NAME (First, Middle, Lest) Donald L. Ca	allic Sr				2. DATE OF DEATH	5, 199	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		yrs. lest birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign	
	218-32-5353 Sa. FACILITY NAME (If not institution, give a	1 🛣 M 2 🗆 F 5		MONTHS DAY		March 2	5,1936	Country) Maryland Y OF DEATH	
TOR	72 Peppermint	,			le River			timore	
DIRECTOR	Maryland Bal	timore		y, TOWN OR LO	River			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	72 Peppermint	Lane			101, ZIP CODE 21220			S.A.	
ВУ	1 Never Married 2 Harried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 X NO	If yes	DECENDENT OF HISPAN, specify Cuban, Maxica	in, Puarto Rican, atc.		Black, White, atc. Specify White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during se retired.)	ATION most of working		BUSINESS/INDUS		
COMP	17. FATHER'S NAME (First, Middle, Last)		Carpen	rer		Construction NAME (First, Middle, Meiden Surname)			
96	William Callis					el Grov			
5	Joan B. Calli:	S	the second second second		ent and Number or Rural int Lane				
	20a. METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from Stata 20b. P	LACE AND DATE or y cremetory or a CKWOOD	of disposition	ery 11/1	DATE 200	Balti	y or Town, State	
	21. SUMMATURE OF FUNERAL SERVICE LIC	Jurfyni	Li'	Bru	zdzinski	Funera		P.A. t.,MD.21221	
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused to List only ona/cause on each s. A LA LA LA LA LA LA LA LA LA LA LA LA L	I C	mal	mode of dyling, auc	th as cerdlec or re	apiratory erres	Approximata Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
PHYSICIAN: MEDICAL C	OADT II Other conditions conditions contain the to death but we see to be a set of the second							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
AN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN **								
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Output	S. PLACE OF DEA	OTHER:	0	112 0001 000			
	27. MANNER OF DEATH 1 Natural 5 Pending	INJURY AT WORK? YES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED						
TED BY	Accident investigation 3 Suicide a Could not be datarmined	2as, PLACE OF INJURY building, atc. (Specify	- At home, Jerm,	street, factory,	offica	28I. LOCATION (Street end Number or Rural Route Number, City or Town, State)			
COMPLETED	onel .	ICIAN: To the beat of my knowled							
BE	29b. SIGNATURE AND SHITE OF CENTIFIE		An		29c. LICENSE NU			SIGNED (Fronth, Day, Year)	
5	30. NIME AND ADDRESS OF PERSON W	O COMPLETED CAUSE OF BEAT	H WEN TO GO	Drinel	17/00			11016)	



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MARYLAND 21215-002	r attending
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TIMORE, MA	Page
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
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		FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIEN	-		
		1. DECEMENT'S NAME (FIRST, MIDDIO,	NAME (First, Middle, Last)					2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH		
2		4. SOCIAL SECURITY NUMBER 212-34-6366	1 M 2 - F	E (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Horith, Day, Ybay) Sep 16	27 14	BIRTHPLACE (State or Foreign Country) aryland	
2. 3 should	CTOR	90. FACILITY NAME (If not institution, 1 orth RESIDENCE OF DECEDEN	nurdel H	Lospital	96. CITY, TOWN O	N Bu		9c. COUNTY	OF DEATH	
. Pages 1.	DIREC	10e. STATE 10b. CO		3.0	y, town on Locat	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
burial-transit permit,	ERAL	100. STREET AND NUMBER 8423 Rugby Road	đ			1. ZIP CODE 21122		10g. CITIZEN	N OF WHAT COUNTRY?	
ag .	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER	S 2 NO	If yes, sp	CENDENT OF HISPAN ecity Cuben, Mexican 2 NO Specify.			. RACE — American Indian, Black, White, etc. Specify: hite	
for use as	LETED	15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12)	B EDUCATION grade completed) College (1-4 or 5+)	(Give kind of a		ON osl of working	16b. KIND OF BU			
detached once.	COMPL	12th Grade 17. FATHER'S NAME (First, Middle, Las	S I)	Printer		18. MOTHER'S NAM	Manufa ME (First, Middle, Malden		g Company	
5 should be notified at	BE	Earl M 190. INFORMANT'S NAME (Type/Print)		risty	ADDRESS (Street a	Margaret	Unkn		Bell	
be pe	임	Kimberly Porsc		857 Cd	omer Squ	are, Bel	Air, Mary	land 2	1014	
director. p		1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVI		ob. PLACE AND DATE (MOTEL AND 1		Park 1 1/18/9			or Town, State , Maryland	
he funeral di ral. I examiner		John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 2120 23. PART I. Enter the Miseeses, or complications that clusted the deeth. Do not enter the mode of dying, such as cardiac or reepiratory errest, Approximata								
n and completely filled in by the funeral director, to burial. cremation. or removal. wmatic event, the medical examiner musi		23. PART I. Enter the diseases shock or heert fell IMMEDIATE CAUSE (Finel disease or condition resulting in death)	lure. Liet only one-Ceuse on	eech line.					Approximata intervel Between Onset end Death	
ending physicia Hygiene prior or other trau	CERTIFICATION	Sequentisity liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	b. COP DUE TO (OR AS	S A CONSEQUENCE OF	F):					
and and	MEDICAL	PART II. Other significent cond					Pert I. 24a. WAS AN PERFOR	RMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
as the	AN:	DID TOBACCO US 25. WAS CASE REFERRED TO MEDIC		CAUSE OF		ACE OF DEATH (Che	Ck only one)			
ertificate h the State [or item	HYSICI	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:		OTHER: 4 Nursing Hom	e 5 🗆 Raeidence	B Cher (Specify)			
this with	ВУ Р	1 Natural 5 Pending 2 Accident Investigs	itlon) INJ	M 1 .	PRK? YES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCUR	ED	
ECTOR: A rs after de n 28 is		3 Suicide e Could no 4 Homicide determin	ot be building, atc. (St	RY — At home, ferm, a pecify)	street, factory, offic		281. LOCATION (Street and City or Town, State)	and Number or F	Rural Route Number,	
THE FUNERAL DIRECTOR: After filed within 72 hours after death PORTANT: If Item 28 is ma	COMPLET		PHYSICIAN: To the bast of my kno						ause(e) end menner ae stated.	
TO THE FUNERA be filed within 7 IMPORTANT: 1	BE	296, SIGNATURE AND TITLE OF CER	JIFIER SMO	Dep	uty	29c. LICENSE NUM DO		29d. DATE SI	IGNEO (Month, Day, Year)	
	10	30. NAME AND ADDRESS OF PERSO	NWHO COMPLETED CAUSE OF E	DEATH (ITEM 27) (Type,	695	- Am	6054 evica	5	1035	
		NOV 1 7 1995	32. PEGISTRAR'S SIG							

TO BE COMPLETED BY FUNERAL DIRECTOR

ITEM : 23 PART I, 28d, PER MEO FILM 6-733 3/16/96 t.t

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO).	
t. DECEDENT'S NAME (First, Middle, Last) LATISHA	DOZ	IER			2. DATE OF DEATH NOV 14	*1995 YEAR	3. TIME OF DEATH 12:40 A M
4. SOCIAL SECURITY NUMBER 218-27-9032	5. SEX 6. AGE (1		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	90 Mount	HPLACE (State or Foreign
9e. FACILITY NAME (If not institution, give s		96	CITY, TOWN O	R LOCATION OF DE	ATH T	9c. COUNTY OF	DEATH
3618 W. BELVEI	DERE AVE	B	BALTIM	ORE CIT	Y	L NH	4
Maryland 10b. COUNT	NA	10c. CITY, TO	OWN OF LOCATI	iore			tod. INSIDE CITY LIMITS? t PYES 2 NO
3618 W. Be	lvedere	Ave.	101.	2121.	5	10g. CITIZEN OF	S A
tt. MARITAL STATUS 1 P Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	t3. WAS DECE If yes, spe t YES	city Cuban, Mexica	IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	a or No— 14. RAC Black	E - American Indian, ik, White, etc.
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	ten. DECEDENT'S USU	done during mos	N t of working	16b. KIND OF BU	SINESS/INDUSTRY	2 / Inter rear
Kindergarten	College (1-4 or 5+)	Stu	Tent	_	50	hool	
BYOGIE	ack			ROSO	ME (First, Middle, Maider	zier	
ROSA Lee	McNeil	36 8	W. Be	Number or Flyral F	Route Number, City or Tox	Balt	n.Md.21215
20e. WETHOD OF DISPOSITION 1 (V Buriel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)	noval from State 20b	PLACE AND DATE OF D	ISPOSITION/Nei	alley	11/20/95 T	DCATION — City or T	own, State
21. SIGNATURE OF FUNERAL SERVICE LA	CENSEE PLU	11/	JOSE	D ADDRESS OF FA	Russ	Funer 10 Ba	al Home
iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A	CONSEQUENCE OF):	NG WOUNDS	S AND ASPH	AND ASP	hypia	Interval Between Onset and Death
PART II. Other algnificent condition			he underlying		1 X YES	N AUTOPSY RMED? 2 NO	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	THED.				
VES 2 □ NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Outp	etlent 3 DOA 4	☐ Nursing Hom-		6 Other (Specify)	IN ILIBA OCCUBA C	UI & ASPHYXIATE
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WO 1 1 Y	RK?	Subjets	stlbe	ASTITIZATE
3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	elfy)	et, fectory, office		281. LOCATION (Street City of Town, State 36(86)	and Number or Number	Multe Number,
TOTAL OTTY	SICIAN: To the best of my know				to the called and it	innot to speed.	My land
296. SIGNATURE AND TITLE OF CERTIFIE	Kong m	r Ar		29c. LICENSE NUI	MBER	29d. DATE SIGNE	D (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DE	111 Pe	enn St	reet, E	Baltimore	e, Mary	Land 21201
31. DATE ELLED (Month Day 1995	To Dayster to	ATURE					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the continuous of the hospital or attending physician.

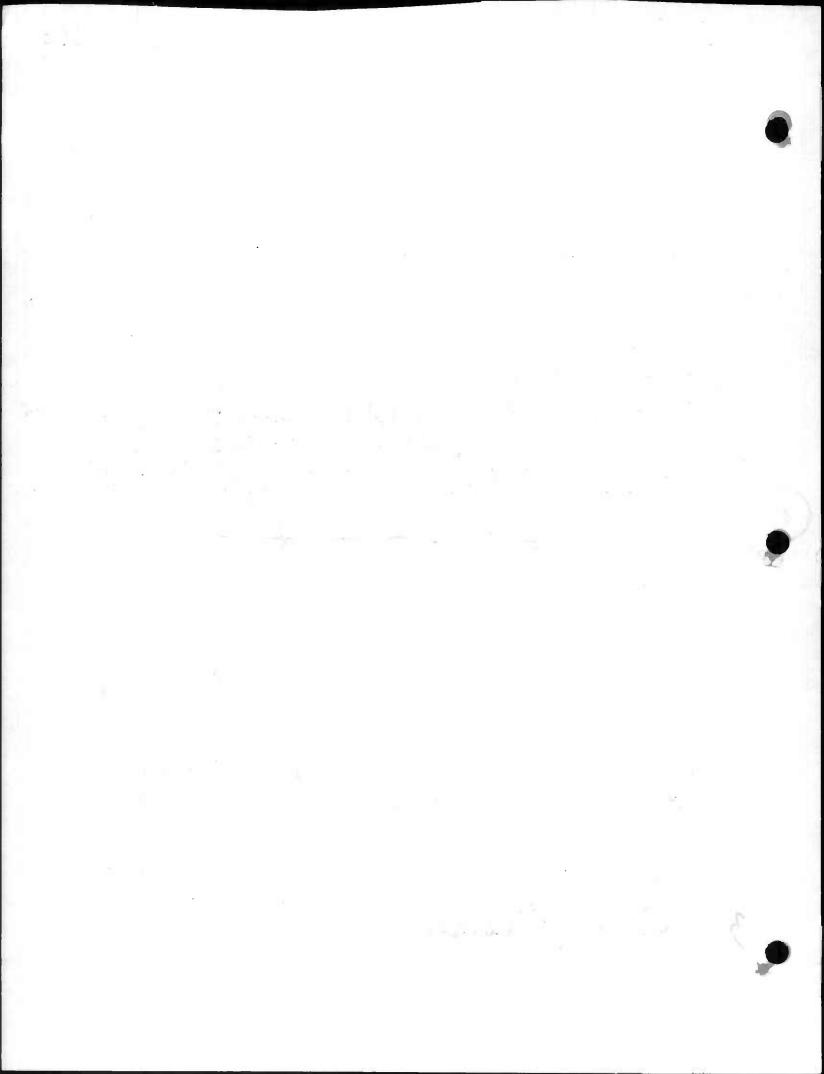
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 687

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



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FOR STATE REGISTRAR

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AVISION OF VILAL RECORDS, P.O. BOX 68/60	1
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1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR BESSIE 4.15 PM HEFMAN NOVEMBER 15 1995 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 - M 2 XF 79 214 18 7515 MAR 5.1916 MARYLAND use as the burlal-transit permit, Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH GOOD SAMARITAN HOSPITAL DIRECTOR BALTIMORE N/A RESIDENCE OF DECEDENT 10d. INSIDE CITY LIMITS? 1 YES 2 NO 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND N/A BALTIMORE FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 4922 ST. GEORGES AVENUE 21212 U.S. OF A. 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, atc. 1 Never Married 2 Married Specify: BLACK BY 3 Wildowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use relired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY for College (1-4 or 5+) HOUSE WIFE HOME MAKER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ie e WILLIAM KEYES MARY NEWMAN BE page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MISS CARLA FREEMAN 3401 FIRELIGHT LA. APT.C BALTO., MD. 21207 20e METHOD OF DISPOSITION

Burlel 2 Cremation 3 Removal 9 DATE 20c. LOCATION - City or Town, State must funeral director, ARBUTUS MEM. PARK 11/21/95BALTIMORE, MAZRYLAND Donation 5 - Other (Specify) 21. SIGNATURE OF FUN. SERVICE LICENSEE examiner LEWIS T. 22. NAME AND ADDRESS OF FACILITY GWYNN LEWIS T. GWYNN FUNERAL HOME 4517 PARK HEIGHTS AVE. BALTO., MD. completely filled in by the lat, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that canced the death. Do not enfer the mode of dying, such as cerdiec or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximete intarval Batween Oneat and Death IMMEDIATE CAUSE (Final cremation, the disease or condition resulting in death) INFARCTION AULTE MYOCARDIAL MIN event. DUE TO (OR AS A CONSEQUENCE OF) and com burial, (traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene primary 10 If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa the attending p Mental Hygiene reaulting in death) LAST 50 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL by and PERFORMED? AVAILABLE PRIOR TO HYPERTENSION any COMPLETION OF CAUSE OF DEATH? signed b 1 YES 2 YAO Shows a VASCULAR DISEASE 1 - YES 2 X 10 t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has by Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Item **EXAMINER?** HOSPITAL:
1 A Inpatient 2 ER/Outpatient 3 DOA OTHER:
4 | Nursing Home 5 | Realdence 8 | Other (Specify) 1 YES 2 NO 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked. 1 Naturel
2 Accident 5 Pending Investigation 1 YES 2 NO BY DIRECTOR: After the 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide .00 6 Could not be COMPLETED 4 Homicide 22 them 29a. CERTIFIER (Check only one)

29a MENICAL EXAMINED: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner se attaled. Ē 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dust to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D The BE M.D aux 108236 NOVEMBER 6 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 900D SAMARITAN HOSPITAL 32 REGISTRAR'S DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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as the burial-transit permit. Pages 1, 2, 3 should

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	FOR	STATE OF MARYLAND	/ DEPAR	RTMENT OF H	EALTH AND I	MENTAL HYGIF	NE .	0	7030
	1 - STATE REGISTRAR			ICATE OF		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	YEAR	TIME OF DEATH
	EVELYN	VIVIAN	110	ANCE			1 1995		1464 M
BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 220-30-1835	5. SEX 1 M 2 F	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Jan 27	935	Aaryla	and
	99. FACILITY NAME (If not institution, give so Saint Joseph Med RESIDENCE OF DECEDENT	9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, Maryland			9c. COUNTY OF DEATH Baltimore				
	10e. STATE 10b. COUNTY	Baltimore City	10c. CIT	ry, town on Locat					d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	27 Miles Avenue	101. ZIP CODE 21211 10g. CITIZEN OF WHA						
	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 45 Divorced	Aerried 2 Merried FORCES? 1 YES 2 XNO			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yee, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES X NO Specify: \$\$pecify:				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 9th	B USUAL OCCUPATION work done during most of working memaker 16b. KIND OF BUSINESS/INDUSTRY In Own Home							
BE COM	17. FATHER'S NAME (First, Middle, Last) Fred Cunningham 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) Ida Fisher								
TO B	190. INFORMANT'S NAME (Types/Print) 190. INFORM								
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Removal from State 4 Donetton 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Complex of Carlot of								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burgee—Henss Funeral HOme 3631 Falls Road Baltimore, MD 21211								
	IMMEDIATE CAUSE (Fine) Onset and Daat disease or condition 1 WEEK								Intarval Between Onset and Daath
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions b.								
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
ER	resulting in deeth) LAST								
_	PERFORMED? AVAILAB COMPLE COMPLE								ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE
MED	DIABETES MELLITUS								1/
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 12								
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 O								
ву рну	27. MANNER OF DEATH 1 Metural 5 Pending Proventigation Month, Day, Year) 28e. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 26d. DESCRIBE HOW INJURY OCCURED								
ED	3 Suicide 6 Could not be datermined 269. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 269. PLACE OF INJURY — At home, ferm, street, factory, office City or Yown, State)								e Number,
COMPLET	ene)	SICIAN: To the best of my knowledge, ER: On the basis of exemination angle							nd menner ee stated.
R	296. SIGNATURE AND TITUE OF CERTIFIE		cli	1/	29c. LICENSE NU	MBER		GIGNED (M	
5	30, NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DEATH (II	EM 27) (3rd	Printi	20001	7		1'	112

RICHARD L. HUSLIG, M.D. 7505 OSLEB DR., SUITE 504, TOWSON, MARYLAND 21204
31. DATE FILED (Month, Day, Year)
NOV 1 7 1995

July Development

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	Fleeti	wood,	SR.		MONTH	OF OEATH DAY		YEAR 195	3. TIME OF DEATH 0.359. M
ron	4. SOCIAL SECURITY NUMBER 218-28-4405	5. SEX 6. AGE (In	MON	THS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	Des Near) 20, 19		Country	PLACE (State or Foreign
	1.	LITY NAME (If not institution, give street and number) HOSPITAL Baltimore City N/A							ATH	
DIRECTOR	10a. STATE 10b. COUNTY Maryland	N/A	OWN OR LOCATION						10d. INSIDE CITY LIMITS? 1	
FUNERAL	10. STREET AND NUMBER 2824 N. Calve	101. ZIP CODE 109. CITIZEN OF WH 21218 U.S.A.								
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: 1 Specify:					— American Indian, Whita, atc.	
COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16e. DECEDENT'S US (Give kind of wor			done during most of working attred.)			b. KIND OF BUSINESS/INDUSTRY			
	8 Construction of the Cons				ion Home Improvement 18. MOTHER'S NAME (First, Middle, Malden Surmarne) Mary Etta Kelbaugh					
TO BE	196. INFORMANT'S NAME (Type/Print) 190. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2824 N. Calvert Street, Baltimore, Maryl								land 21218	
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 4 Donestion 5 Other (Specify)									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. Alan Seitz, Jr. Funeral Ho 3818 Roland Ave. Baltimore. M										vland 21211
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF):									Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									2 415 5415.
AL	PERFORMED? 1 □ YES 2 XNO								WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
CIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:									
PHYSICIAN: MEDIC	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1) Inpatient 2 ER/Outpa 28a. DATE OF INJURY (Month, Dey, Year)		Nursing Hom 28c. INJ W0	RK?		r (Specify) CCRIBE HOW INJURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datarminad	28e. PLACE OF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify) 28f. LOCATION City or Town						I (Street and Number or Rural Route Number, n, State)		
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or invextigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER A SAD, FARHANA 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typs, Print)								(Month, Dey, Year)	
-	30. NAME AND ADDRESS OF PERSON WE	V PKWY	2 BALT		RE 1	MD	-21	21	8	ı
	31. DATE FILED (MONTH, Day Your 1	32. REGISTRAR'S SIGNA	TURE							

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 how and the flue of many be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. DECEDENT'S NAME (First, Middle, Last)		4			PEAIN	2. DATE OF DEATH	0.1		3. TIME OF DEATH		
BERNARD	GERCZ						Nov 13 1995 0719				
4. SOCIAL SECURITY NUMBER 212-46-9191	5. SEX 1 M 2 F	6. AGE (In yrs. Ia:		IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) 05-24-1947		BIRTHPLACE (State or Foreign Country) Marvland			
Sa. FACILITY NAME (If not institution, give at	,			96. CITY, TOW	N OR LOCATION OF D			INTY OF DE			
University of	BALTIMORE			N/A							
10a. STATE 10b. COUNTY	,		10c. CITY,	TOWN OR LO	CATION		10d. INSIDE CITY				
Md. N/A	Md. N/A						1xx				
100. STREET AND NUMBER			101. ZIP CODE			10g. CI1	HAT COUNTRY?				
307 S. Highland	Avenue		21224			U.S.A.					
11. MARITAL STATUS 1 Never Married XX Merried 3 Widowed 4 Divorced	13. WAS DECENDENT OF HISPANIC ORIGIN? (5 If yes, specify Cuben, Mexican, Puerto Rica 1 ☐ YES 2 🎇 NO Specify:										
15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY									te		
(Specify only highest grade Elementary/Secondary (0-12)	(Specify only highest grade completed) (Give kind of work of the Do NOT use not										
10	k Lift	Opera	ator	Ali	Alitrista						
17. FATHER'S NAME (First, Middle, Last)		16. MOTHER'S NAME (First, Middle, Meiden Surname)									
Bernard R. 190. INFORMANT'S NAME (Type/Print)	Gerczak	1	h Man nic	1000000 10	Marie	Dummond Route Number, City or R	Carta S	in Cod-1			
Martha Gerczak						e.Balto.,M					
20e. METHOD OF DISPOSITION 1 Burial 2 & Cremetion 3 Rem		20b. PLACE	AND DATE O	FDISPOSITION	(Name of		OCATION -		wn, State		
1 Burial 2 S Cremetion 3 Rem 4 Donation 5 Other	oval from State	Green!	nount	Cemete	ery 11/3	15/95 Ba	lto.,	Md.			
21. SIGNATURE OF FUNDAMENTAL	ENSEE	2/1	1		AND ADDRESS OF F		01 1		21231		
23. PART I. Enter the diseasea, pr			anth Da a			er Inc. 19			Approximate		
ahock, or heart failure.				ot enter that	moda bi dying, su	on an cardiac or rea	piretory a	rreat,	Interval Between		
disease or condition ENDOCATION INS WITH ADMIL PLOT ARSLESS							5 Dhas				
resulting in death)	DUE TO	OR AS A CONSE			1.010(12	, , ,	~~>>				
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Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING THE PROPERTY OF THE PROPER								1 Horn			
CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS A CONSEQUENCE OF):										
reaulting in death) LAST	that initiated events										
PART II Other algorificant condition	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDING										
TATE III. COMMITTEE CONTINUES	PERFORMED?							AMILABLE PRIOR TO COMPLETION OF CAUSE			
									OF DEATH?		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO YUNCERTAIN											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
1 YES 2 NO	HOSPITAL: 1 Manpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28e. DATE OF (Month, D		266, TIME INJU	URY	INJURY AT WORK? YES 2 NO	26d. DESCRIBE HOV	V INJURY O	CCURED			
3 Sulcide 6 Could not be determined	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29e. CERTIFIER 1 CERTIFYINO PHYS	ICIAN: To the best of	my knowledge, d	leath occurre	d at the time,	date end place, end du	ue to the cause(s) and r	nanner as a	tated.			
one) 2 MEDICAL EXAMINI	ER: On the beels of er	remination end/or	r Investigation	n, in my opinio	n, death occured at th	ne 1lme, date end place,	and due to	the ceuse(e	e) end manner es stated.		
200 SIGNATURE AND TITLE OF CERTIFIE	R				29c. LICENSE N	JMBER	29d. D/		E SIGNED (Month, Day, Year)		
1 Julia		D46015			Nov 13, 1995						
30. NAME AND ADDRESS OF PERSON WE	DEAL	SE OF DEATH (IT	EM 27) (Type,		OF MAT	mLAND					
22 5. Impane		R'S SIGNATURE		Mo.							
31. DATE FILED (Month, Day, Year) NOV1 7 1995	ale devile	Park !!									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed written 24 hours counts. Page 6 may be n	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5		IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be m
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3 Suicide

4 Homicide

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3 TIME OF DEATH 1995 November 14, 6:25 A. GERARD EDWARD GRAY, JR. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 💢 M 2 🗌 I 218-36-5246 55 Maryland April 25,1940 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Towson Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY Maryland Harford Bel Air 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21014 U.S.A. 600 Idlewild Road 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Merried 2 X Merried Specify: White 1 YES 2 X NO Specify: BY 3 Widowed 4 Divorced ED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use refired High School History Teacher 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only h Elementary/Secondary (0-12) College (1-4 or 5 +) Private High School COMPL 8 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme, Gerard E. Gray, Sr. Mildred Sokolowski BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 (wife) 600 Idlewild Rd., Bel Air, MD 21014 Carol Anne Gray 20a, METHOO OF DISPOSITION
1 X Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State John's Cemetery 11/18 Long Green, Maryland 4 Donetton 5 Other (Specify) . 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home of Bel Air, Inc. 610 W. Mac Phail Rd., Bel Air, MD 21014 23. PART I. Softer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel astatic Unknown premar disesse or condition Canses monte resulting in desth) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? MAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL PLACE OF DEATH (Check only one) EXAMINER? OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6X Other (Specify) Hospice fent 2 [] ERVOy 0 28c. INJURY AT WORK? 27. MANNER OF DEATH 28b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Nevatural 1 YES 2 NO BY 2 Accident PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)

29e. CERTIFIER (Check only one)

A MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination sector investigation, in my opinion,

29b. SIGNATURE AND TITLE OF CERTIFIER 29d. OATE SIGNED (Month, Day, Your) 290 LICENSE NUMBER 4

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2300 DULANEY VALLEY RD., TOWSON, MD DR. EDDIE NAKHUDA

31. DATE FILED (Month, Day, Year)

6 Could not be

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

261. LOCATION (Street end Number or Rural Route Number, City or Town, State)

6.

1 -

STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Last)

OCIAL SECURITY NUMBER

IF UNDER 1 YEAR DAYS HOURS Pages 1, 2, 3 should TOWN OR LOCATION OF DEATH DIRECTOR mor more permit. 10f. ZIP CODE FUNERAL completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 24 hours after death. Page 6 may be retained by the hospital or attending physician. WAS DECEMENT EVER IN U.S. APFORCES? 1 YES 2 1 NISPANIC ORIGIN? (Specify Yes or No-13. WAS DECENDENT OF If yes, specify Cy en, Mexican, Puerto Rican, atc.) 1 Never Married 2 🗸 Specify: BY 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION

The blad of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple College (1-4 or 5+) Prv (0-12) 0 be notified at once 0 THOD OF DISPOSITION must 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one ceuse on 0 IMMEDIATE CAUSE (Final cremation, other traumatic event, the disease or condition colon Metastatue cancer reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): executed with burial, CERTIFICATION and Sequantially list conditiona, **OUE TO (OR AS A CONSEQUENCE OF)** attending physician a It any, laading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 OR ATTENDING PHYSICIAN: The law requires that the death the atten Mental H any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL signed by the 23 shows has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔼 UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only of Item After this certificate death with the State HOSPITAL OTHER: 1 YES 2 NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 8 Other (Specify) 0 27. MANNER OF DEATN 28c. INJURY AT 28e. DATE OF INJURY 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED marked, 5 Pending M 1 YES 2 NO BY investigation Accident 28e. PLACE OF INJURY — At home, ferm, streat, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Sulcide 60 DIRECTOR: A hours after de COMPLETED 4 Homicide 28 determined Item 29e. CERTIFIER TERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 h On the beele of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Da6794 2 name and address of person who completed cause of Death (ITEM 27) (Type, Print)

Barbara A. Conley Mb Univ MD CancerCtr Barbara A. Conley 22 Si Greene St

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

2. DATE OF DEATH

OV

REG. NO

24a. WAS AN AUTOPSY PERFORMED?

1 YES 2 NO

INSIDE CITY

1 YES 2 NO

interval Between

Onaat and Death

WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION DF CAUSE

1 YES 2 RO

OF DEATN?

29d. DATE SIGNED (Month, Day, Year)

11-16-95

10g. CITIZEN OF WHAT COUNTRY?

RACE

DHMH-18 Rev 1/89

Balto 21201

00812 L

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4

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or the billy

STATE REGISTRAR

JAMES

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

218-46-8853

5 SEY

15 M 2 | F

1 -

BIRTNPLACE (State or Foreign Country)

Maryland

N/A

Specify.

white

YEAR

1995

REG. NO.

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year,

NOV.13

June1,1947

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Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL ER BALTIMORE 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore Lansdowne permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1928 Victory Drive 21227 United States the burial-transit within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-12. WAS DECEDENT EVER IN U.S. ARMED If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: FORCES? 1 YES 1 Never Married 2 X Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced use as ETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) jō Elementary/Secondary (0-12) College (1-4 or 5+) COMPL should be detached 8 warehouse liquor 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) notified at Robert C. Horn Marie C. McGainey BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Catherine Horn 1928 Victory Drive Lansdowne, page pe 20a. METNOD OF DISPOSITION
1-U Burlet 2 Cramation 3 Removal from Stata
1 Constitution 5 Other (Specify) 20c. LOCATION — City or Town, State 20h. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, cametary crametory or other place) Meadowridge Memorial 11/17 Dorsey, Maryland examiner RAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home of Lansdowne au in by the fur removal. Hada 2719 Hammonds Ferry Road medicai 23. PART I. Enter the diseases, or conplications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, ahock, or heert fellure. List Dnly Dne cause on each line. Filled IMMEDIATE CAUSE (Finel the cremation disease or condition_ Ser æ resulting in deeth) traumatic event, TO YOR AS A CONSEQUENCE OF burial, executed CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to If any, leeding to immediate attending physician ntal Hygiene prior to pe cause. Enter UNDERLYING CAUSE (Disease or injury certificate other t DUE TO (OR AS A CONSEQUENCE OF) thet initieted eventa resulting in death) LAST 6 death the atten Mental injury, PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY MEDICAL the I Health and N shows any 1 TYES 2 NO been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO TO UNCERTAIN TO PHYSICIAN: has be Dept. MP 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL The EXAMINER? FUNERAL DIRECTOR: After this certificate I within 72 hours after death with the State HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1X YES 2 NO 1 Inpatient 2 XER/Outpatient 3 IDOA ng Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b, TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED Natural Natural marked, INJURY 5 Pending 1 YES 2 NO BY Accident 26e. PLACE OF INJURY - A1 home, term, atree1, tectory, office Sulcide 26f. LOCATION (Street end Number or Rural Route Number City or Town, State) 8 Could not be determined 8 COMPLETED 4 Nomicide 28 Item 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) end menner as stated. = TO THE HOSPITA
TO THE FUNERAL
BE filed within 72
IMPORTANT: II 2 💢 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occured at the time, date and piece, end due to the cause(e) and manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE SLETED CASSE OF DEATH (TEM 27) (Type, Print) OCME 2 DONAE 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTS R'S SIGNATURE 7 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS.

MIN.

HOURS

HORN

MONTHS

6. AGE (In vrs. last birthday

48

3. TIME OF DEATN

10d. INSIDE CITY LIMITS?

14. RACE — American indien, Black, White, atc.

1 TES 2 NO

21227

21227

Approximate

24b. WERE AUTOPSY FINDINGS

OF DEATN? 1 YES 2 NO

NOV.14,1995

AVAILABLE PRIOR TO COMPLETION OF CAUSE

Interval Between

Onaet and Deeth

Maryland

16:02 PM

DHMH-16 Rev 1/89

by the hospital or attending physician.	be detached for use as the burial-transit permit. Pages 1, 2, 3 should	at once.
O THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 months and earth. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE	TO THE	IMPOF

31. DATE FILED (Month, Day, Year) NOV 1 7 1995

32. REGISTRAR'S SIGNATURE

								9:	5	3411) 1
	1 - STATE OF MAI	RYLAND / I	DEPAR RTIF	TMENT OF	HEALTH F DEAT	AND I	MENTAL HYGIEN REG. NO	E			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	ш	veig	3. TIME OF DE	EATH
	Patrick Ronald	Krine	er				November	13,1	.993	4:35	Рм
		AGE (In yrs. last I	birthday)	IF UNDER 1 YEAR	-		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTN Countr	PLACE (State or	Foreign
	216-62≈6871 1 × M 2 □ F	42	YRS.	MONTHS DAY	HOURS	MIN.	Dec. 21.	1952	Per	n nsulva	nia
	9a. FACILITY NAME (If not institution, give street and number)			96. CITY, TOW	N OR LOCATIO	N OF DE		9c. COUN			
TOR	Maryland General Hospi	tal		Balt	imore	Ci	Lty	Ва1	tim	nore C	ity
DIRECTOR	Maryland Baltimor	.e	10c. CIT	Y, YOWN OR LO	CATION	Du	ndalk			10d. INSIDE CLIMITS?	
FUNERAL	100. STREET AND NUMBER 4236 Lynhwrst Road				101. ZIP CODE	2122	22			State	
₽	11. MARITAL STATUS 12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 K NO		If yea,		, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		14. RACE	E — American ir k, White, etc.	odlen,
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elsmentary/Secondary (0-12) College (1-4 or 5 +) 1 Years	(Give	e kind of v Do NOT us	vork done during se retired.)	most of working		16b. KIND OF BUS	iness/ind		2010	
M	17. FATNER'S NAME (First, Middle, Last)		Urwn	Much			ME (First, Middle, Maiden		uin	LOYL	
					22002		E. Greenaw				
B	Clifford Kriner 19a. INFORMANT'S NAME (Type/Print)	19b.	MAILING	ADDRESS (Stra	_		Route Number, City or Tow		Coriel		
임	Mr. Clifford Kriner	1					Dundalk, Ma			01000	
	20a. METNOD OF DISPOSITION			DEDISPOSITION		u		CATION -			
	1 Burial 2 (X Cremation 3 Removal from State 4 Donation 5 Other (Specify)					11	117/95 Tou	NA AM	Man	would	
	21. SIGNATIVE OF PANERAL SERVICE LICENSES	- Illian	1	22. NAME	AND ADDRES	S OF FA	CILITY				
	· (hel W. tim	h		79	22 Wis	e Au	ineral Home	Ck. M	D 2	lalk, I.	nc.
	23. PART i. Enter the diseases, or complications that constant is shock, or heart failure. List pnly one cause	nused the dee	th. Do r	ot enter the	node of dyli	ıg, suc	h es cerdiec or reap	ratory arr	est,	Approx	Imate Between
	IMMEDIATE CAUSE (Final	01. 02.0									nd Death
	resulting in death) a. Bradyc	ardia	/As	stole						unkn	own
	· ·			,		a:					1.1-7
Z	Sequentially list conditions, Brain				post	: Ch	PR.			1 d	ay
ERTIFICATION	if sny, leading to immediate	AS A CONSEDU	UENCE O	F):						,	
2	CAUSE (Disease or Injury	Plug									nown
	that initiated events resulting in deeth) LAST	AS A CONSECU	JENCE O	F):						CXAL!!NE	
斯 	d					_				CAR CARD	
0	PART II. Other aignificant conditions contributing to de-	ath but not re	aulting	in the underly	ing cause g	ivan in			a ab	WERE STOPS	
2	History of Brain Inj	ury w	ith	Subar	achno	oid	PERFOI		M.	COMPLETION C	
	hemnorrhage						OF RETHYCATH	1	/ `	OF DEATH?	□ NO
2	DID TOBACCO USE CONTRIBUTE TO CAUS	SE OF DEAT	TH YI	S 🗆 NO	☐ UNC	ERTAII	N D SEED N	1/			_ ,,,,
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL			TH (Check only o			10				
Sic	EXAMINER? 1X YES 2 NO 1 X Inpatient 2 E	R/Outpatient 3 (DOA	OTHER:	ome 5 Re	sidence	8 Other (Specify)				
Ŧ	27. MANNER OF DEATH 28e. DATE OF INJ	JURY	28b. TIM	E DF 28c.	INJURY AT		28d. DESCRIBE HOW	NJURY QCC	CURED	س داد	
	1 Netural 5 Pending (Menth, Day, 1	444	125	JURY SPM 1	WORK? YES 2	Luo	THE AJ		,	,	
ВУ	3 Suicide 280. PLACE OF IN	NJURY - At hom	ne, farm,	street, factory, o			28/. LOCATION Street	Prod Number	for Duray	Ploute Numb	ب لا كال
品	4 Homicide determined building, atc.	, (ървску)	2	57255	1		Bearing of lown, State			277	MO
	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my					and due					
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the basis of exam									s) and manner a	a stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICE	NSE NUI	MBER	29d. DATE	E SIGNED	(Month, Day, Ye	er)
BE	I. Gendelsman	_ /	u:	P		392		1	1-1	15-95	
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH (ITEM	27) (Type	, Print)				. 1		-5 75	
	30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print) Inna Gendelsman, M.D. c/o Maryland General Hospital										

DHMH-18 Rev 1/89

IC,

be retained by the hospital or attending physician. **MARYLAND 21215-0020** BALTIMORE, Раде 6 тау after death. 6876 BOX 2 outificate 0.0 DIVISION OF VITAL RECORDS, HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the

death o

1 -STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First, Middle, Last) LOPEZ AL NovemBRK Sept. 25 uerto Rico 2866 MONTHS DAYS HOURS MIN 1 🗌 M 2 😿 F permit. Pages 1, 2, 3 should TOWN OR LOCATION OF DEATH DIRECTOR 10d. INSIDE CITY 10c. CITY TOWN OR LOCATION 1 TYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? FUNERAL IOe. STREET AND NUMBER 10f, ZIP CODE 2 ear burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14, RACE — American Indian, Black, White, atc. 1 Never Married Married IF YES, GIVE WAR OR DATES YES 2 NO | Specify: BY 3 Wildowed 4 W Divorced use as the panic COMPLETED 15. DECEDENT'S EQUICATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Give kind of work done e Do NOT use retired.) for dery (0-12) 9 detached Once. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sui ani funeral director, page 5 should be notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Nu 2 ean be 200 METHOD OF DISPOSITION DATE, must Cremetion 3 [4 Donation 5 Other (Specify) Joseph 1222 examiner 21. SIGNAPOUE OF FUNERAL SERVICE in by the f VV. Nor medical Enter the diffesses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, enock, or heart failure. List only one cause on each line. 23. PARTI Approximeta Intervel Between Onset and Death IMMEDIATE CAUSE (Finel ä disease or condition reaulting in deeth) event, 8 and cod traumatic MEDICAL CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other that initiated events the attending resulting in death) LAST 6 shows any injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TES 2 NO 1 YES 2 NO been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN 🗵 PHYSICIAN: has be Dept. Item 23 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL R: After this certificate ha er death with the State D is marked, or item **EXAMINER?** HOSPITAL OTHER 1 Onpetion 2 ER/Outpetion 3 DOA

28e. DATE OF INJURY (Month, Day, Year)

18 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Netural 1 YES 2 NO DIRECTOR: After the hours after death we litem 28 is mark Investigation COMPLETED BY 2 Accident 28s. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Sulcida a Could not be 4 Homicide determined 29e. CERTIFIER To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. (Check only one) FUNERAL I IMPORTANT: 11 BE HE HE 223 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Lucius III despita a filipa

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flow with the HOSPITAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERTIF	ICALE	: OF	DEAL	Н	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) JOSEPH	LEDERMAN				" .		2. DATE OF DEATH MONTH DA		YEAR	3. TIME OF DEATN
			and the Atlanta				-	NOV 15)	1995	0342 A M
		Ø M 2 □ F 83	yrs. last birthday) YRS.	IF UNDER	DAYS	HOURS	NAME OF TAXABLE PARTY.	7. DATE OF BIRTN (Month, Day, Year)	0	Country	,
	9a. FACILITY NAME (If not institution, give street	- 00		Sh CITY						POL	
æ	ST. AGNES HOSPITAL			30. 0111,		TIMOF		"		NTY OF DE	
DIRECTOR	RESIDENCE OF DECEDENT				DITT	31 11101			DAL	LIMUR	E CITY
H H	10e. STATE 10b. COUNTY		10c, CIT	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY LIMITS?
ā		ALTIMORE		CAT	ONSV	/ILLE					1 TYES XX NO
FUNERAL	10e. STREET AND NUMBER	~			10f	. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
ÿ	440 WESTSHIRE DRIVE	Ľ				212	228			U.S	.A.
5	11. MARITAL STATUS 12. 1 Never Married 2 X Married	. WAS DECEDENT EVER IN U FORCES? 1 YES	J.S. ARMED 2 X NO	13. V	MAS OEC	ENDENT OF	HISPANIC Mexican	ORIGIN? (Specify Yea Puerto Rican, etc.)	or No-	14. RACE Black	— American Indian, White, atc.
ВҰ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	ES			2 X NO		,		Specif	y:
	15. DECEOENT'S EQUICATION	ON I	6a. DECEDENT'S	USUAL OC	CUPATIO	IN .		16b. KIND OF BUS	INCOC/INI	DUCTRY	WHITE
	(Specify only highest grade com	ollege (1-4 or 5+)	(Give kind of a life. Do NOT us	work done d				IOU. KIND OF BOS	INESS/INI	7031HT	
립	12TH GRADE		SALES	MAN				CLOT	HING	ı F	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHE	R'S NAME	E (First, Middle, Maiden S	Surname)		
BE	UNKNOWN LEDERM	IAN					UNK	CNOWN			
0	19a. INFORMANT'S NAME (Type/Print)							ute Number, City or Town			
F	NANCY LEDERMAN		440 W	ESTSI	HIRE	DRIV	/E -	CATONSVIL	LE,	MD 2	21228
	20a. METNOD OF DISPOSITION 1 Burial 2 X Cremation 3 Removal		LACE AND DATE (DATE 20c. LOC		•	vn, Stata
	4 Donation 5 Other (Specify)	HI	LLTOP S						<u>OWSO</u>	N	
13	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC.										
1	yells?	1		410	07 W	ILKEN	IS AV	ENUE-BALT	TMOR	E, MI	21229
	23. PART I/Enter the diseases, or companies shock, or heart fellure. List	plications that caused to	ha daath. Do r	ot antar 1	the mo	de of dying	g, such	aa cardiac or respir	atory an	reat,	Approximata
- 1	shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death										
	disease or condition resulting in death)	acute	Myoc	and	ill	my	luce	him			30 min.
		DUE TO (OR AS A C	ONSEQUENCE OF	F):		0					
CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A CO	ry a	nte	14	Oles	e ha	e			
F	if any, leading to immediate cause. Enter UNDERLYING	DOL TO (ON AS A C	ONSECUENCE OF):	,						
윤	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF	j:							
토	resulting in death) LAST										
	DART II ON I - W III										
EDICAL	PART II. Other aignificant conditions co						an in Pa	ert i. 24s. WAS AN A PERFORM			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	Dinhete	es, non in	mulin ,	deper	nde	nt		_ 1 _ YES 2)	No		COMPLETION OF CAUSE OF CEATH?
Σ	DID TODA CCO LICE CON TRUE										1 TYES 2 700
A N	DID TOBACCO USE CONTRIBUTION OF THE PROPERTY O					UNCE	RTAIN				
PHYSICIAN:	EXAMINER?	OSPITAL:	PLACE OF DEAT	OTHER	:						
¥ I	27. MANNER OF DEATN	Inpatient 2 PER/Outpatie	ent 3 L DOA		Ing Nome			Other (Specify)	HIEW OO	Ounen.	
	1 Natural 5 Pending	(Month, Day, Year)	INJ		WOR			8d. DESCRIBE NOW IN	JUHY OCI	CURED	
BY	2 Accident Investigation 3 Suicide 6 Could and be	26s. PLACE OF INJURY -	At home, farm, s	treet, factor			_	6t. LOCATION (Street an	od Number	or Rural Bo	siste blambur
밀	4 Homicide 6 Could not be datarmined	building, atc. (Specify)			,,			City or Town, State)	~	Or Fibral Fib	was Namosi,
9	290. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the heat of my knowled	in death accura	4 - 4 4 - 4							
COMPLET	(Check only one) 2 MEDICAL EXAMINER: Or	: To the beat of my knowled n the beals of examination a									and manner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENS					
8	Peldar Line	4 120			- 1	D 34		-			Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WNO CO	OMPLETED CAUSE OF DEATH	H (ITEM 27) (Type.	Print)		- 17	00		· NOV	vvvvi.	215,1995
	REBECCA LOVE MD				T) A	TTTMA)DE	MD 2122	0		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATI	<u>CATON</u>	AVE.	BA	LTIMO	KE.	MD. 2122	9		
	1101 1 1992 Jelia	Develor Rada	K								
	6'										



80.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

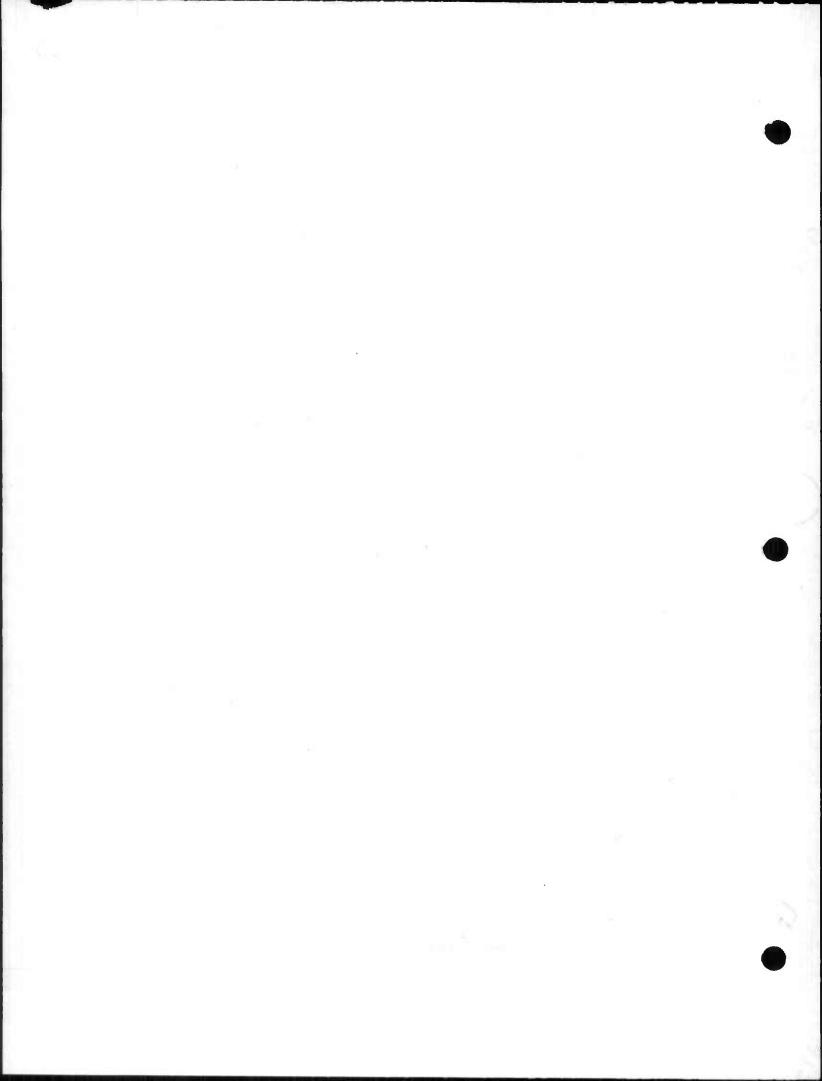
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE PEGISTRAP

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR		CL	-1771111	CAIL		DEATH	REG. NO.			
,	1. DECEDENT'S NAME (First, Middle, Last) Margaret Anna	Marx						2. DATE OF DEATH DO NOVEMBER		1995 3.	SIO AM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YE	EAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	, ,		ACE (State or Foreign
	214-44-4464	1 □ M 2XXF	89	YRS.			HOURS MIN.	Oct. 28,1	906	Mary.	
	9e. FACILITY NAME (If not institution, give s	street and number)			9b. CITY, TO		LOCATION OF DE			NTY OF DEAT	
S.	1107 Gladway					\mathcal{B}	Baltimor	e	1	Baltim	iore
DIRECTOR	RESIDENCE OF DECEDENT										
#	10e. STATE 10b. COUNT			toc. CITY	, TOWN OR L					10-	d. INSIDE CITY LIMITS?
	Maryland	Baltimore	2		В	alt	timore			1 1	YES 2 X NO
AL	10e. STREET AND NUMBER					101. 2	ZIP CODE		_	IZEN OF WHA	T COUNTRY?
8	1107 Gladway						21220		u	.S.A.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WAS	DECE	NDENT OF HISPAN	NC ORIGIN? (Specify Yes	or No-	14. RACE -	American Indian,
	1 Never Married 2 Married	FORCES? 1	YES 2 X	10			cify Cuben, Mexica 2 X NO Specify	n, Puerlo Rican, atc.)		Black, W Specify()	Thine, arc.
BY	3 X Widowed 4 Divorced						7				nue
	15. DECEDENT'S EDU (Specify only highest grade	CATION	18e. DE	CEDENT'S	USUAL OCCU	PATION	N of supplies	18b. KIND OF BUS	SINESS/INC	DUSTRY	
ᇤ	Elementary/Secondary (0-12)	College (1-4 or 5			rork done durir e retired.)	ng most	t or working				
릴	6th grade			Homen	naker			Ou	in Hoi	me	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			-			16. MOTHER'S NA	ME (First, Middle, Meiden	Sumame)		
BE C	Frank Turek						Elizab	eth Fu	ıka		
	19e. INFORMANT'S NAME (Type/Print)			b. MAILING	ADDRESS (Si	treet and	d Number or Rural I	Route Number, City or Tow	rn, State, Zip	p Code)	
2	Charlotte Edmons	ton (dgh	tr)	1107	Gladu	vau.	, Baltin	ore. MD 2	1220		
	20g. METHOD OF DISPOSITION t	310	20b. PLACE	ANDDATEC	F DISPOSITIO	ON (Nam	ne of	DATE 20c, LO	CATION -	City or Town,	State
	t X Buriel 2 Cremation 3 Ren 4 Donetion 5 Other (Specify)	noval from State	HOLLU	matery of of	her place)	l G	ardens	11/18 Ba	ltimo	ore. M	aryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1								
	21. SIGNATURE OF TOTAL PROPERTY OF EXCENSE				Sch	umi	inek tun	eral Homes d., Baltin	, In	C.	1021
	4-7.0	FU/									256
	23. PART i Phar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, abock, or heart feliure. List only one cause on each line. Approximate interval Between										
- 1	Onset and Deat									Onset and Death	
	disease or condition regulting in daeth)	· PUL	MONAN	7 F/	15ん05	15					15 ma.
- 1		DUE TO	(OR AS A CONSE	OUENCE OF	F):						
z		b									
CERTIFICATION	Sequentielly list conditions, if eny, leeding to immediate	DUE TO	(OR AS A CONSE	OUENCE OF	F):						
S	ceuse. Enter UNDERLYING CAUSE (Disease or Injury	с									
E	thet initiated events	DUE TO	(OR AS A CONSE	OUENCE OF	F):						
ᇤ	resulting in death) LAST	d									
	PART ii. Other algnificant conditio	na contributing to	deeth but not	reeuiting i	in the unde	rlylna	ceuse alven in	Part i. 24a, WAS AN	AUTOPRV	24b W	ERE AUTOPSY FINDINGS
EDICAL	VALUE OF STATE OF STA	The Continuously to	doctri bat not i	toouting t	in the unde	7,118	Couse given in	PERFO	RMED?	AW	MILABLE PRIOR TO
ă								t _ YES :	NO	OI	F DEATH?
ME							,			1	☐ YES 2 NO
ż	DID TOBACCO USE CONT	RIBUTE TO CA					UNCERTAIL	1 🗆			
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	CE OF DEAT	TH (Check only	y one)					
SI	1 TES 2 TO	t inputiant 2 [ER/Outpatient 3	DOA	OTHER:	g Home	Reeldence	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	26e. DATE OF (Month, J.		28b. TIM	E OF 28	Bc. INJU WOR		28d. DESCRIBE HOW	INJURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation	N	A			1 🗌 YI		NIA	1		
	3 Suicide 8 Could not be	28e, PLACE (OF INJURY — At he	ome, ferm,	street, fectory	, office		28f. LOCATION (Street City or Town, Stete	end Numbe	or Rural Rou	te Number,
TED	4 Homicide determined	bending	N A					Only or lown, steels	,		
E	29a. CERTIFIER CERTIFYING PHYS	SICIAN: To the best of	f my knowledge da	eath occurr	ed at the time	date (end place, and due	to the cause(e) end ma	oper es ete	eted:	
COMPLET	(Check only							time, date end place, e			nd manner ea stated.
8			4								
BE	296. SIGNATURE AND TITLE OF CERTIFIE	5 1	~//				DICI /	MBEH	29a. UA	IL SIGNED (M	forth, Day, Year)
5	20 NAME AND ADDRESS OF STREET	, , , , , , , , , , , , , , , , , , ,	()	14 07 7	0-1-**		11869	D	1	11/6/	, ,
	30. NAME AND ADDRESS OF PERSON W	O COMPLETED CAU			-		9518.	B GHILA	RD		
	7 FLI1001 V	1 1161		rtw)!	(130	41.,20	212	5/	
	31. DATE FILED (Month, Day beg) 32. REGISTRAR'S SIGNATURE										



		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTME				GIENE G. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	M.	1 . 1	enna		2. DATE OF DE	ATH DAY	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. lest birthday) IF U	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIF	TH	8. BIRTHPI	LACE (State or Foreign
pino	1	98. FACILITY NAME (If not institution, give street	1 M 2 OF			HOURS MIN.		0,32	Country)	Mary and
1, 2, 3 should	CTOR	NOVYM AVUNDE L	Jospital	96.	alen	BUTNE	EATN	AMN.	LAVU	ndel
Pages	DIRE	Mary 1 and Anno	3 3 - 3 3	10c. CITY, TOV		TION				IOd. INSIDE CITY LIMITS?
permit.		Maryland Anne 10e. STREET AND NUMBER	Arundel1	<u> </u>		. ZIP CODE		10g. CITIZ		AT COUNTRY?
is.	FUNERAL	236 Harlem Road	12. WAS DECEDENT EVER IN U	II A ADMED		21122				States
215-0020 attending physician. se as the burial-transit	B	1 Never Merried 2 Kinarried 3 Wildowed 4 Divorced	FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 V NO	I1 yes, sp	ENDENT OF HISPAI ecify Cuban, Mexica 2 NO Specify	in, Puarto Rican,	cify Yes or No— etc.)	Specify:	- American Indian, Whita, stc.
	TED	15. DECEDENT'S EDUCA' (Specify only highest grade co	empleted)	16a. DECEDENT'S USUA (Give kind of work de life. Do NOT use retin	one durina ma	ON ast of working	16b. KIND	OF BUSINESS/INDU		11100
29	COMPLETE	Elementary/Secondary (0-12)	College (1-4 or 5+)	linewor	,		bak	ery		
A aft a		17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA				
MARYI retained by 5 should be notified at) BE	George Johnson 19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDR	RESS (Street a	Amanda			Code)	
2 2 2	2	James F. McKenn		236 Har	lem 1	Road Pa				21122
FORE e 6 may ector, pag must b		20a. METHOD OF DISPOSITION 1 (Burlet 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from Stata cemet	PLACE AND DATE OF DIS tery, crematory or other pla adowrida	ece)			DOMESTICAL		
- Pa -	3	21. SIGHARDING OF PHINERIAL BERVICE LICEN	IMG.		22. NAME AN	ND ADDRESS OF FA	CILITY			
BALT after death. by the funera moval.			agan		2719	ose Fun Hammon	ds Fer	rv Roa	d 2	1227
in the		23. PART I. Enter the disesses, or con shock, or heart failure. Lie	nplications that caused to it only one cause on eac	the deeth. Do not er ch lina.	nter the mo-	de of dying, suc	ch ss csrdlec o	respiratory srre	est,	Approximats Interval Between
ely fill nation,		IMMEDIATE CAUSE (Finsl disesse or condition resulting in death)	Febrile	Natro	peni	a (seo	sis)			1 W K
N 2 5 - 6	_		Metastah	CONSEQUENCE OF):	110	-11 6-	1 H	- 14		10
	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF):	re(ii (ell (a	1	16 100)	10 moning
D by	FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF):						
U = 8 + 5	ERI	resulting in death) LAST								
= 2 × 2 =	7	PART II. Other significant conditions	contributing to death but	t not resulting in the	underlying	g csuse given in	Part I. 24a. V	WAS AN AUTOPSY PERFORMED?		/ERE AUTOPSY FINDINGS
RECORE requires that th een signed by t of Health and i	EDIC/						10	YES 2 NO	C	OMPLETION OF CAUSE OF DEATH?
She les	Σ	DID TOBACCO USE CONTRII	BUTE TO CAUSE OF	DEATH YES] NO [] UNCERTAIN	N 🗆		1	YES 2 NO
日 音 音 日	PHYSICIAN:		IOSPITAL:		IER:					
1 일 등 등	HYS	1 YES 2 NO 1	inpatient 2 ER/Outpati	28b. TIME OF	28c. INJI	e 5 Residenca URY AT		NOW INJURY OCCI	URED	
ON OD DING PHYS After this death with	BY F	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	1 U Y	PRK? (ES 2 NO				
TISI TTEN TOR: after	TED	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, stc. (Specify,	- At home, farm, street,	factory, office	•	28f. LOCATION City or Town	(Street and Number of State)	or Rural Rou	rte Number,
DIV L OR A L DIREC 2 hours	COMPLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	AN: To the best of my knowled	dge, death occurred at I	he time, data	and place, and due	to the cause(s) a	nd menner as state	d.	
HOSPITAL FUNERAL WITHIN 72 I	COM		On the besis of exemination s	and/or investigation, in n	ny opinion, de	eath occured at the	Ilme, data and pl	aca, and dua to tha	cause(s) a	nd manner as stated.
TO THE HOSPIT TO THE FUNERA be filed within 7	쀪	296. SIGNATURE AND TITLE OF CENTURER	M.O.			DH74	14-2-1			fonth, Day, Year)
7 558€	임	30 HAME AND ADDRESS OF PERSON WHO C			2 1					ba -12-91
)		All Saily, North	- Arundel F	tospital,	501 1	Hospita	1 Our	Glen	Bum	ic, My 21091
		NUV1 77995	Contract de	fall						

X

lineworker

bakery

ac

:Kenna Jr.

Amanda Harris

236 Harlem Road Pasadena, Maryland 2112

Meadowridge Memorial 11/16 Dorsey, Maryland
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Road 2127

DIVISION OF VITAL RECORDS, P.O. BOX 6876

BALTIMORE, MARYLAND 21215-0020

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and director, page 5 should be retained by the hospital or attending physician.

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	FOR 1 - STATE	STATE OF MA					MENTAL HYGIEN	E	35 34/00
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) MICHAEL	STEV			ROD	F DEATH	2. DATE OF DEATH MONTH DATE NOV 13 1	995	3. TIME OF DEATH 11:08 P M
	4. SOCIAL SECURITY NUMBER 051-36-4092	1 💢 M 2 🗌 F	. AGE (In yrs. lest	YRS. MO	UNDER 1 YEA	B HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV . 6, 1941	8.	BIRTHPLACE (State or Foreign Country) NEW YORK
TOR	98. FACILITY NAME (If not institution, give st 7121 BRANCHWO		CE	96		NTON	EATH	PRIN	V OF DEATH NCE GEORGES
DIRECTOR	10a. STATE 10b. COUNTY	CE GEORGE		10c. CITY, TO		CATION			tod. INSIDE CITY LIMITS? t \(\text{YES} 2\folda{1}\) NO
FUNERAL	7121 BRANCHWOOD					101. ZIP CODE 20735		U.S.	N OF WHAT COUNTRY?
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 _ IF YES, GIVE WAF	YES 2 N	MED O	If yes	DECENDENT OF HISPAI , specify Cuban, Maxica YES 2 X NO Specif		or No — 14	t. RACE — American Indian, Black, White, atc. Specify: WHITE
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 YRS 18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ECONOMIST CONOMIST 18. MOTHER'S NAME (First, Middle, Last)						166. KIND OF BUSINESS/INDUSTRY CENSUS BUREAU		
ш	PRILLIP NAROD NETTIE MOSCO 199 INFORMANT'S NAME (Resp.Print)							Surname)	
10	Pal. INFORMANT'S NAME (Type/Print) NETTIE NAROD 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or 33-65 14TH STREET - LONG ISLAN								
20s. METHOD OF DISPOSITION 1 X Burial 2 Cremetion 3 Ramoval from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of campatery, cremetory, or other place) ARARAT CEMETERY 20c. LOCATION — Cify or Town, State 11/17 FARMINGDALE, NY.									
	21. SIGNATURE OF FUNERAL SERVICE LIC	Coleman	/		4107	WILKENS A	L HOME, IN	IMORE,	
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition recuiling in death)	a. Cuteri	e on each line.	tic C			Dise		Approximete Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	OR AS A CONSEC						
MEDICAL C	PART II. Other significent condition	e contributing to d	eeth but not n	esulting in t	the under	ying ceuse given in	Pert I. 24a. WAS AN PERFO!		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN: 1	DID TOBACCO USE CONT	RIBUTE TO CAU		TH YES			N D ASP	elen	
YSIC	EXAMINER? t X YES 2 □ NO	HOSPITAL: 1 Inpetient 2 E		□ DOA 4	THER:	Home 5X Residence	8 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF IN (Month, Day,	(Year)	28b. TIME C	Y M 1	INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCU	RED
<u>B</u>	3 Suicide e Could not be 4 Homicide detarmined	28a. PLACE OF building, at	INJURY — Al hor c. (Specify)	ma, farm, stre	et, lactory,	offica	28f. LOCATION (Street City or Town, State	and Number or	Rural Route Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI MEDICAL EXAMINE								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER O. C. M. E 290. DATE SIGNED (Month, Day, Year) NOV 14, 1995								

111 Penn Street,

21201

Maryland

Baltimore,

BALTIMORE, MARYLAND 21215-0020

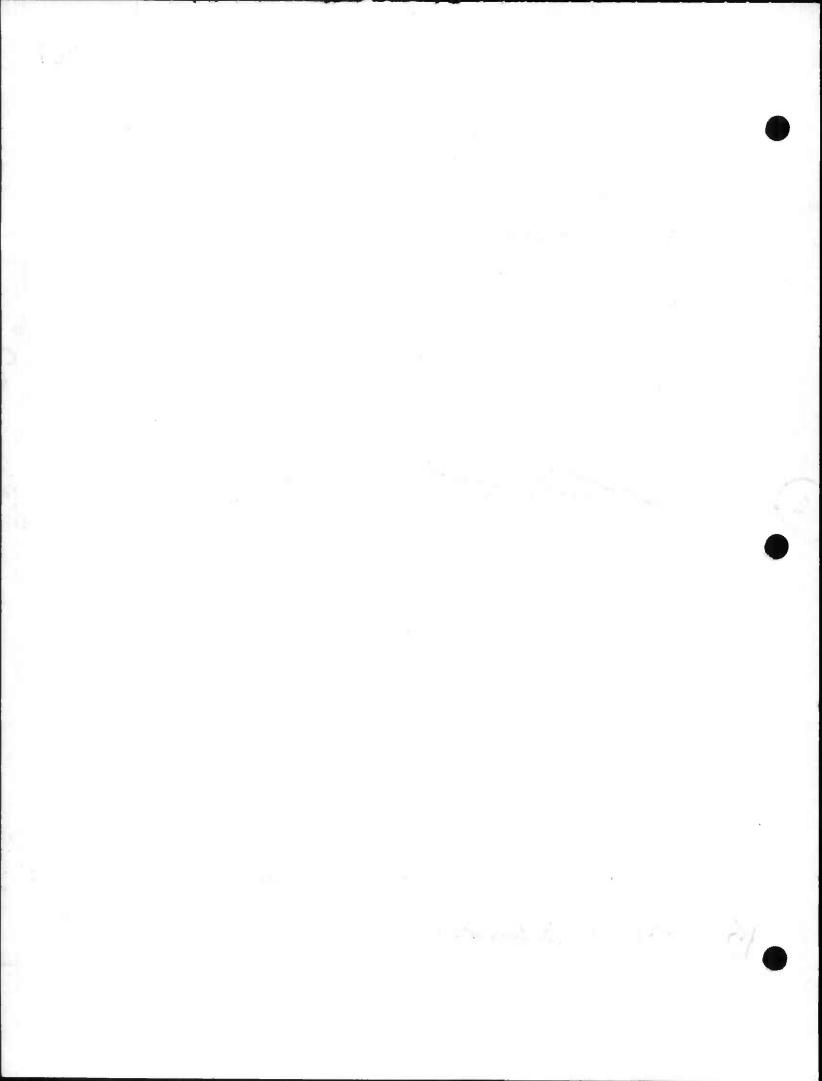
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	for 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM				IENE . NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA			3. TIME OF DEATH	
l	EMILY	CURLEY		PENNY		NOVEMB:	ER 11.	1995	2:50A	M
	4. SOCIAL SECURITY NUMBER 5.		rs. last birthday) #F	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	Н	8. BIRTHP	LACE (State or Foreig	gn
	217-36-9075 9s. FACILITY NAME (If not institution, give street	□ M 2 🛣 F 90	YRS.	CITY TOWN OF	HOURS MIN.	(Month, Day, You 3/12/(05	MARY INTY OF DE	LAND	
DIRECTOR	THE JOHNS HOPKI		30		IMORE CI		96. 000	NIT OF DE	N/A	
E	10e. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATION	ON				10d. INSIDE CITY	\neg
	MARYLAND BALT	TIMORE		ARNEY			1		1 YES 2 NO	,
FUNERAL	V	1500		107.	ZIP CODE		10g. CIT		HAT COUNTRY?	- 1
N N	8800 WALTHER BLVD.	APT. 1503 . WAS DECEDENT EVER IN U.S	S ARMED	13 WAS DECE	21234 NDENT OF HISPAN	IC OBIGIN2 (See	the Year or No.	USA	— American Indien.	-
	1 Never Married 2 Married	FORCES? 1 YES 2	NO	If yee, spe-	city Cuban, Mexices	n, Puarto Ricen, et		Black,	White, etc.	1
B	3 💢 Widowed 4 🗌 Divorced	IF TES, GIVE WAN ON DATES	3	I U TES	Z AJ NO Specify	r:		Specify WI	HITE	
ED	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION 16	e. DECEDENT'S USU	JAL OCCUPATION	V	16b. KIND (F BUSINESS/IN			
<u> </u>		College (1-4 or 5+)	(Give kind of work life. Do NOT use re	tired.)	t or wonang					
필	12th GRADE		TELLER				BAN	K		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, A	feiden Surname)			
шІ	HUGH CURLEY				MYRT	LE CAST	E			
10 B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street an	d Number or Rural F			p Code)		
F	H. JAY PENNY		1101 R	OWAN CO	OURT BA	LTIMORE	MD 2	1234		
	20s. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal		ACE AND DATE OF D		ne of	DATE 2	Dc. LOCATION	City or Tov	vn, State	
	4 Donation 5 Other (Specify)	TVY	HTLL CF		11	/14/95 1	LAUREL,	MARY	TLAND	
	21. SIGNATURE OF FUNERAL SERVICE LINEN				ADDRESS OF FA					
	1 // 1/				ON FUNER		mor to	0.7	- 01000	
	Secret L Eyler the diseases, or com				OCH RAV			ON M	Approximate	_
	hock, or heart fallure. List	I Dnly Dne ceuse on each	ine.						Onaet and D	
	IMMEDIATE CAUSE (Final disease or condition	CARDIAC	Annes	-					125 M	10
	resulting in dasth) s	DUE TO (OR AS A CO		71					0	11/
_		S/D HYS	TERFC.	Tann	1				14 da	40
CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A CO	ONSEQUENCE OF):	1						1
S	CAUSE (Disease or Injury	15CHEN	IIC H	EAR	1 71	SEAS	E		yea.	()
띮	that initisted evente	DUE TO (OR AS A CO	ONSEQUENCE OF):	1-1	2.0				1. 06	
EH	resulting in dasth) LAST	FUNDOV	TETIC	IAC	CH				ana	- 14
	PART II. Other eignificant conditions of	contributing to death but	not resulting in t	he underiving	cause given in	Part I. 24a. V	AS AN AUTOPSY	24b.	WERE AUTOPSY FIND	INGS
CAL						Р	ERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CALL	
ED						_ 'U'	YES 2 NO		DF DEATH?	
Σ	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YES	П NO П	UNCERTAIL	νП			1 YES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		OTTOLINA					-
SIC		OSPITAL:		THER:	5 🗆 Residence	6 1 Other (Speci	60			\neg
¥	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O	F 28c. INJU	JRY AT	28d. DESCRIBE		CCURED		\neg
	Natural 5 Pending	(Month, Day, Yeer)	INJURY		RK? ES 2 NO .					- 1
ВУ	2 Accident investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY -	At home, term, stre-	et, fectory, office		261. LOCATION	Street and Numb	er or Rumi A	loute Number,	\neg
	4 Homicide detarmined	building, etc. (Specify)				City or Town	, State)			
E	29e. CERTIFIER	N: To the best of my knowled	an doub assumed	d the time date		to the councile of	orazan en	dia.		
COMPLETED	one)	On the besis of examination er							and manner se stat	nd la
8				· IIIy opinion, o						-
BE	296. SIGNATURE AND THE OF CERTIFIED	AT PAY-1	0136	IN -	1 1 1 1 1	/ /	29d. DA	TE SIGNED	(Month, Day, Year)	781
6	30. NAME AND ADDRESS OF PERSON WHO O	COMPLETED CALLSE OF DEATH	H //TEM 277 /5-72 A	HHI	דווען	/		VBV	11,11	/ 2
	ANNE HA	RDART	MD -	HAL	600	NWO	LFE	ST.	BALTIM ND 217	787 NA
	31. NEVE (MOTIN: 1995) July	3 REGITIRARY GN T	IL.		J				,	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a second of the complete and the complete and the complete and completely find in the following physician and completely find in the following physician and completely find in the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or manner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 . STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CER	TIFICAT	TE OF	DEATH		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE O	OF DEATH		ишла.	3. TIME OF DEATH
	DAVID JACKSON PULLEN				Nover	9 48		995	7:00 a. M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birth		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE C	Day, Year)		8. BIRTN	PLACE (State or Foreign
	237-46-0799 1XIM2DF 63 Y	'AS. MONTH	DAYS	HOURS MIN.		1/32		Country Hali	
	9e. FACILITY NAME (If not institution, give street and number)	9b. CI	TY, TOWN C	R LOCATION OF D		1 50		NTY OF D	
8	VA MEDICAL CENTER		FO	RT HOWAR	2D		BATA	TIMOR	E COUNTY
DIRECTOR	RESIDENCE OF DECEDENT						Diana	-11101	W 0001111
뿐	10a. STATE 10b. COUNTY 104	c. CITY, TOWI	OR LOCAT	ION /					10d. INSIDE CITY LIMITS?
	MDIVIA		9/-	-i mo	re				1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER		101	ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
	1308 Ken WOOD Ave.			2121	13			4.	5. A.
Ē	11. MARITAL STATUS 12. WAS DECEDENT ÉVER IN U.S. ARMED 1 Never Marriad 2 Ad Marriad FORCES? 1 YES 2 NO	1	3. WAS DEC	ENDENT OF NISPAI	NIC ORIGIN?	(Specify Yes	or No-	14. RACE	- American Indien, White, etc.
BY	IF YES, GIVE WAR OR DATES	- 1	1 TYES			cent, etc.)		Specif	,
	1935-35								PIACK
COMPLETED	(Specify only highest grade completed) (Give kir	ENT'S USUAL nd of work don VOT use retired	e durina mo	N st of working	16b.	KIND OF BUS	SINESS/IND	USTRY	
וה	Elementary/Secondary (0-12) College (1-4 or 5+)	4 1	T	10.00	. ~	T		1/	
₹ I	17. FATHER'S NAME (First, Middle, Last)	uc)		rive	77	IY	·uc	K	ng
	S. D. L. D.	,		18. MOTNER'S NA		~	Sumame)	1	2
ا ل <u>ا</u>	190. INFORMANT'S NAME (Type/Print)				, Ni		1017	110	ON
2	Doct-1-1/0 1/0 1/2	ALLING ADDRE	1 -	nd Number or Rupin		or, City or Tow	n, State, Zip	Code)	100
	20e. METNOD OF DISPOSITION	108		N WOO		HVR	1B	4/1	1/1/10 2/2/3
1	1 Thursd 2 Cremation 3 Removal from State Cemetary cremator	OATE OF DISP	OSITION (Ne	me of	2 AJE	20c. LO	CATION -	City or To	wn, State
- 1	4 Denation 5 Other (Specify)	SUT	45		195	51/tr	DO	170	(S, MID)
- 1	9. 1.0//	· · · ·	Z. NAME AN	D ADDRESS OF FA	FILLIA F	3043	741	ner	al Hame
	- Willren compette		129	N. Car	line	St	Bo	: 140	MN21212
П	23. PART 1/Enter the diseases, or complications that caused the death.	Do not ent	er the mo	de of dylng, suc	h as cardi	ac or respi	ratory arr	est,	Approximate
	shock, or heart failure. List only one cause on each line.								Interval Between Onset and Death
	disease or condition ASPTRATTON PNET	MONIA							24 HRS.
	resulting in death) a	CE OF):			·				2-F 111(D).
2	MULTIPLE CEREBR	OVASCU	JLAR	ACCIDENT	'S				6 YRS.
2	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENT)								O IIID.
HIFICALION	CAUSE (Disease or Injury	NEURYS	SMAL (CLIPPING					6 YRS.
-	that initiated events OUE TO (OR AS A CONSEQUENCE			22277110					O IIID.
E	resulting in death) LAST								
2	DADT II Other confident conditions contain the start of all the								
3	PART II. Other significant conditions contributing to death but not result					24a. WAS AN PERFOR	MED2	24b.	WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO
5	STATUS POST GASTROSTOMY, CHRONIC R	ENAL	AILU	RE, CACH	EXIA	1 TYES 2	ŅO		COMPLETION OF CAUSE OF DEATH?
2									1 TES 2 NO
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	YES 🗆	ИО □	UNCERTAIL	NX				
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF HOSPITAL:	DEATN (Chec							
2	1 YES 2 NO Inpatient 2 ER/Outpatient 3 Do			5 Residence	6 - Other	(Specify)			
PH TSICIAN:	(Month, Day, Year)	. TIME OF INJURY	28c. INJI WO		28d. OESC	RIBE NOW II	JURY OCC	URED	
6	1 Natural 5 Pending 2 Accident Investigation	М		ES 2 NO					
S	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, for building, etc. (Specify)	erm, street, fe	ctory, office		281. LOCAT	TION (Street a	nd Number	or Rural Re	oute Number,
	4 Homicide determined				J., J.,	ionii, dialej			
COMPLEIE	29e. CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death or	ccurred at the	time, date	end place, end due	to the caus	e(s) and man	ner es atate	nd.	
	MEDICAL EXAMINER: On the basis of examination end/or invest								and manner se stated.
	29b. SIGNATURE AND TURLE OF CENTIFIER								
4	1//			D 434					(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)	/Time Delin		V 777	-0		1	1/14	/ 95
			معدامة الا	0600	ODET	0077			
	DR. JOSEPH SNIADACH, M.D., DVA MEDI(31. DATE FLED (Morith, Day, Voor) 32. REGISTRAR'S SIGNATURE	UAL CE	MTER,	9600 N	URTH I	TVIIOS	ROAD	, FT	. HOWARD 21
	NOV4 71000								
T.	110 1 1995 July divolver harber								

80.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a foath. Page 6 may be retained by the bispital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled mind, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 hours afty death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

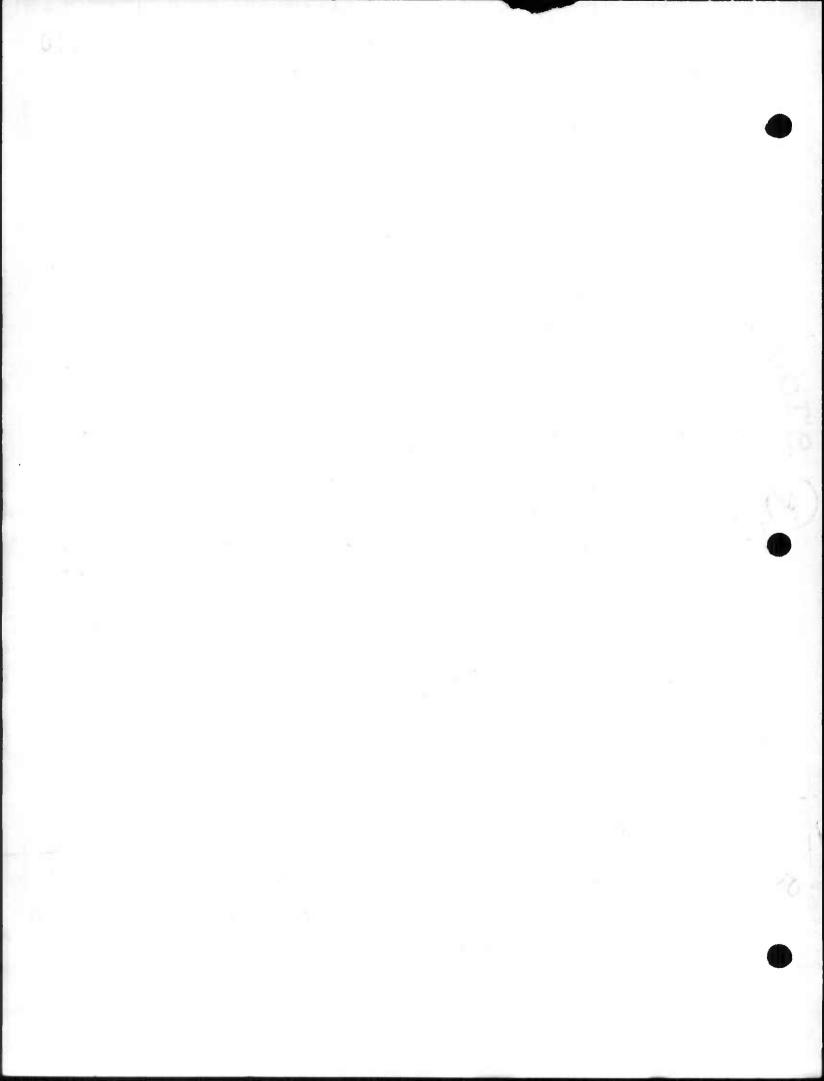
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH
	Samuel Thomas I	Poness , Jr.					November	15	1995	6:47 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YE			7 DATE OF BIRTH		8, BIRTH	IPLACE (State or Foreign
	101-12-2270	1 📉 M 2 🗀 F	84 yas.	MONTHS DA	IYS HOURS	MIN.	Month, Day, Year,	11	No i	w York
	9a. FACILITY NAME (If not institution, give a	street and number)		9b. CITY, TO	WN OR LOCATIO				INTY OF D	
FUNERAL DIRECTOR	Fort Howard V.	A. Medical	Ctr.	Fo	rt How	ard		B	alti	more
Ä	10a. STATE 10b. COUNT		10c, CIT	Y, TOWN OR L	OCATION					10d. INSIDE CITY
	Maryland	Baltimore				Di	undalk	*		LIMITS?
*AL	100. STREET AND NUMBER				10f. ZIP CODE					VHAT COUNTRY?
Ë	2816 Yorkway A	ipt. B				21:	222	U	Inite	d States
5	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EVER FORCES? 1XXYES		13. WAS	DECENDENT OF	F HISPANI	C ORIOIN? (Specify, Puerto Rican, etc.)	Yea or No-	14. RACE	— American Indian, c, White, etc.
Β¥	3 Widowed 4 Divorced	IF YES, OIVE WAR OR			YES 2 X NO				Speci	
	15. DECEDENT'S EDU	ICATION		Hellal Cook	DATION				<u> </u>	withe
	(Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of life. Do NOT us	work done durin	PATION g most of working	g	16b. KIND OF I	BUSINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 4 Years	Teac				Board	lofE	duca	tion
OM	17. FATHER'S NAME (First, Middle, Last)				16. MOTH	ER'S NAM	E (First, Middle, Maid			
U U	Salvatore Thomas	s Poness. St.					evera Tri		,	
BE	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (St			oute Number, City or 1	1 1		
2	Mrs. Victoria R.	Poness					, Maryla			Apt. B
	20a. METHOD OF DISPOSITION 1 & Burial 2 Cremation 3 Ram	20	b PLACE AND DATE	OF DISPOSITIO	N /Name of		CATE 200	OCATION	City or To	Canto
	4 Donation 6 Other (Specify)		metery, cremetory or o	n Cema	teru 1	1/18	195 (Blen F	Burni	e. MD
	12 Buriel 2 Cremation 3 Removal from State Completel 2 Cremation 3 Removal from State Completel 2 Completel 2 Completel 3									
	> hallh	1. truck		Duc	ia⇔Kuck	tun	eral Home	2061	unda	er, Inc.
	23. PART I. Enter the diseases, or	complications that cause	d the death. Do	of anter the	mode of dvir	AUE	. Dunda	CR, ML	7 21	
	shock, or heart failure.	List only one cause on	esch line.		modu or dyn	·g, 55011	Carolac Of 18	ipiratory ar	iwat,	Approximats interval Batween
	IMMEDIATE CAUSE (Final disease or condition	STIVE HEA	מאבי יים	TIDE					Onset and Death	
	resulting in death)	F1	A CONSEQUENCE OF		LUKE					5 weeks
ا ج	_	RENAL	INSUFFIC	ÍENCY						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	F):						1
3	cause. Enter UNDERLYING	c.								
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):						
	resulting in death) LAST	d								
	PART II. Other algorificant condition	as contributing to death	but not resulting	In the under	lylna cause a	lvee le D	Darie I 04- 440	AL ALITTORNA	1	
MEDICAL			but not resulting	iii trie dildei	lyllig cause g	IVÆII III P		AN AUTOPSY ORMED?	240.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
	-						1 □ YES	2 (3) NO		OF DEATH?
	DID TORACCO LISE CONT	DIDLITE TO CALICE (DE DEATH M	c C No		EDTA:				1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUSE (26. PLACE OF DEA			KIAIN				
S	EXAMINER?	HOSPITAL:		OTHER:						
Ĕĺ	27. MANNER OF DEATH	1 Sinpetiant 2 ER/Out			Home 6 Ree		Other (Specify) 28d. DESCRIBE HOY	V IN III III CO	CUBEC	
	1 Natural 6 Pending	(Month, Day, Year)		URY	WORK?		and, DESCRIBE MOY	TINJURT OC	COMED	
B	2 Accident Investigation 3 Suicide & Could not be	26a. PLACE OF INJUR	Y — At home, farm, s				26f. LOCATION (Street	at and Numbe	r or Burni B	inute Number
	4 Homicide 6 Could not be determined	building, etc. (Spi	ectly)	,			City or Town, Sta		O NUMBER	oute Namber,
9	29a. CERTIFIER A XX CERTIFYING BUYER	CIAN. To the head of the		With the Control	- Andrews	20 - 0 - 1				
COMPLETED		ICIAN: To the best of my know IR: On the basis of examination								
ပ္ပ			and/or investigatio	n, m my opink						1112222
出	296. SIGNATURE AND TITLE OF CERTIFIES	who to t	1.0		29c. LICE					(Month, Day, Year)
6	30. NAME AND ADDRESS OF PERSON WH	-	· / / /	1	דע	136	2	14	ovem	ber 15, 1995
	George E. Wicks				Road Fo	rt H	oward M	210)52	
		7, 32 REGISTRAR'S SIGN		OIIIL I	load 10	T L 11	oward, FI	210	116	
	NUV 1 / 1995 Au	32, REGISTRAR'S SIGN	LIL							

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and the Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		ej.
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	N 24	ly fi	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE	OF DEATH	REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEN REG. NO.	E					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIN	E OF DEATN			
	Violet Shirley	Pollard				MONTH DA	15 19	IAC 5	08a. H			
			In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	NOVEMBER 7. DATE OF BIRTH			(State or Foreign			
	317-18-7469 1 - M 2 X F 71 YRS. MONTHS DAYS HOURS MIN. (Morth, Day, Year) Country) Feb. 22, 1924 Indiana											
1	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											
DIRECTOR	Union Memorial Hospital Baltimore City N/A											
<u>n</u>	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. II	NSIDE CITY			
	Maryland	N/A	Balt	imore					IMITS? YES 2 NO			
A	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	OF WHAT C	OUNTRY?			
FUNERAL	3214 Belair Road				21213		U.S.	Α.				
5		. WAS DECEDENT EVER IN	U.S. ARMED			IIC ORIGIN? (Specify Yes			erica <i>n</i> Indian, , atc.			
BY F	1 Never Married 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 YES	TES X		2 NO Specify	n, Puarto Rican, etc.)	- 1	Specify: Wh				
								****	100			
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	iON npleted)	16a. DECEDENT'S U (Give kind of wo	SUAL OCCUPATION rk done during moing retired.)	N st of working	16b. KIND OF BUS	SINESS/INDUST	TRY				
ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfe. Do NOT use	retired.)								
M M	12th grade		Homemake	r		Own Ho						
8	17. FATHER'S NAME (First, Middle, Last) William Slate Dalt	ton				ME (First, Middle, Meiden a Smith	Surname)					
BE		2011										
6	19s. INFORMANT'S NAME (Type/Print)					nore, Mary						
	Edward C. Pollard	(Husband)	5214 De	Tall NO	au, Dait	Imore, rary	Tanu Z	21213				
	20ayMETNOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	trom Stats	PLACE AND DATE OF etery, cremetory or other Ce	er plece)	me o/ 11/19/0	1	CATION City					
	21. SIGNATURE OF FUNE L SERVICE LICENS		IRWOOD OC	22. NAME AN	D ADDRESS OF FA	CILITY	imore,	Maryı	and			
	11-	111		Schimu	nek Fune	ral Home						
	the b	ll_		3331 E	rehms La	ne; Baltin	nore, M	D 212	13			
	23. PART I. Phter the diseases, or com- shock, or heart failure. Lis-	plications that caused	the deeth. Do no	t enter the mo	ds of dying, suci	h ss cardiec or reapi	ratory arrest		Approximats			
- 1	ahock, or heart failura. List only one cause on each line.											
- 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. MY O CATCLICAL INFLORMANT IOROUTS OUR WAS A CONSEQUENCE OF: WELFACTOR											
	OUE BY OR AS A CONSEQUENCE OF											
Z	Companielly list conditions											
E I	If any, leading to immediate											
2	CAUSE (Disease or Injury											
#	that initiated avanta resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF									
CERTIFICATION	d											
	PART II. Other aignificant conditions of	contributing to death b	ut not reaulting in	the undariying	cause given in	Part I. 24s, WAS AN	AUTOPSY	24b. WERE	AUTOPSY FINDINGS			
CAL	COPD, HO	IDERTE	NSIO	U DE	PIPH	F- PERFOR	MED?		ABLE PRIOR TO LETION OF CAUSE			
MEDIC	PIAI MIC	CULAR	0100	CACE	7777	1 D YES 2	NO	OF DE	ATH?			
Σ	DID TOPACCO LISE CONTRIL	CO CAUSE O	EDEATH VE	MAIOL	LINICERTAIN			1 0	rES 2 NO			
AN	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH	NO [UNCERTAIL	1						
PHYSICIAN:	EXAMPLER?	IOSPITAL:		OTHER:								
IXS	1 VYES 2 NO 1	☐ Inpetient 2 ☐ ER/Outp		- T		6 Other (Specify)						
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	RY WO	RK?	26d, DESCRIBE NOW I	NJURY OCCUR	RED	-			
BĄ	2 Accident Investigation	00- 01 40F 05 IN INDI			ES 2 NO							
COMPLETED	3 Suicide 6 Could not be 4 Homicide datermined	26e. PLACE OF INJURY building, etc. (Spec	reet, tectory, omc	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
Ë	290. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowl	ladge death seems	I at the time det	and place and dis-	to the neverted and and						
MP	(Check only one) 2 MEDICAL EXAMINER:							euse(a) and r	namer on stated.			
	29b. SIGNATURE AND/TITLE OF CERTIFIER											
BE	To los de d	elant.	5/1.		1 TO	120011	29d. DATE S	IGNED (Month	Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF THE	ATH (ITEM AT C	2-1-41	AIXY	20196	-//	115	193.			
•	Vladimiv Ka	Kite lark	AIR (IIEM 27) (lype, l		Memori	al Word to	1	2,111	LM arm			
	NOV 1 7 1995	32. REGISTRAR'S SIGN.	ATURE	3.101	1.1011011	WI TOTALL	×1 1	JUL II	THE THE			
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		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
		1. DECEDENT'S NAME (First, Middle, Last) Peddicord 2. DATE OF DEATH MONTH DAY 95 165 M										
pin		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) 76 98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH										
1, 2, 3 should	DIRECTOR	Anne Arundel Medical Center Annapolis Anne Arundel										
mit. Pages		10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIOE CITY LIMITS? 10e. STREET AND NUMBER 10e. STREET AND NUMBER										
ling physician. the burlal-transit permit. Pages 1, 2,	FUNERAL	106. STREET AND NUMBER 107. COOE 108. CITIZEN OF WHAT COUNTRY? 108. CITIZEN OF WHAT COUNTRY? 119. COOE 109. CITIZEN OF WHAT COUNTRY? 110. MARITAL STATUS 110. COOE 110. CITIZEN OF WHAT COUNTRY? 110. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No.— 14. RACE — American Indian,										
attending physician. ise as the burial-trar	D BY FI	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cubin, Mexican, Puerto Ricen, etc.) 3 Wildowed 4 Divorced FYES, GIVE WAR OR DATES 1 YES 2 AND Specify: Specify: White, atc.										
al or	COMPLETE	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work dorned wiring most of working life. Do NOT use retired.) 17. College (1-4 or 5 +) 18b. KIND OF BUSINESS/INDUSTRY										
I by the hospit d be detached d at once.	w l	17. FATHER'S NAME (First, Middle, Last) John Francis Peddicord 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydie May Moreland										
ay be retained by page 5 should be t be notified at	TO B	19a. INFORMANT'S NAME (Types/Print) Rose Peddicord 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Polling House Road, Harwood, MD 20776										
6 m ctor,		20b. PLACE AND DATE OF DISPOSITION Name of Commetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Commetton 3 Removal from State Complete, compatory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of Commetton 2 Concentration) 20c. LOCATION — City or Town, State 20c. LOCATI										
after death. Page by the funeral dire smoval. Ical examiner r		Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, mD 21401 23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or reapiratory errest. Approximate										
with ours in pletely filled in the cremation, or re-		Approximate interval Batween ones or complications that caused the death. Do not anter the mode of dying, such as cardiec or reapiratory errest, ehock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):										
th certificate be execuending physician and I Hyglene prior to bur or other traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evanta resulting in death) LAST DELATED DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
in the	AL C	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PRIOR TO COMPLETION OF CAUSE OF DEATH?										
law requires the as been signed Dept. of Health a 23 shows any	AN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO										
SICIAN: The law certificate has b the State Dept. 1, or item 23	PHYSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ONO										
this with	ВУ	28a. DATE OF INJURY 1 Netural 5 Pending Investigation 28a. DATE OF INJURY (Morth, Dey, Year) 28b. TIME OF INJURY WORK? M 1 YES 2 NO 28b. PLACE OF INJURY — At home, ferm, street, factory, office 28b. PLACE OF INJURY — At home, ferm, street, factory, office 28b. LOCATION (Street and Number of Rural Route Sent)										
DIRECTOR: After hours after death	LETED	4 Homicide determined building, atc. (Specify) City or Town, State)										
TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h IMPORTANT: It is	E COMPLI	(Check only one) 2 MEDICAL EXAMINER: On the beals of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year)										
TO THE DE FIEC	TO BE	30. NEMME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
		31. DATE FILED (MORITI, DBY, YBBI) 32. REGISTRAR'S SIGNATURE NOV 1 7 1995 Full divelented 2 0776										
		DHMH-16 Rev 1/89										

24 hours after death, Page 6 may be retained by the hospital or attending physician, BALTIMORE, MARYLAND 21215-0020

use as the burial-transit permit, Pages 1, 2, 3 should

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the attending physician Mental Hygiene prior to

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After t death

DIRECTOR: /

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6876 DIVISION OF VITAL RECORDS, P.O. BOX certificate be OR ATTENDING PHYSICIAN: The law requires that the death

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 1995 9:43 A Clara Margaret Rose November 11 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 F Sept. 11 Virginia 230-09-6168 9e, FACILITY NAME (If not institution, give street end number) 9h CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Square Hospital Baltimore Franklin Rossville 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore. Dundalk 1 TYES 2 Y NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21222 1102 Fallwood Court United States 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. 11 yes, specify Cuben, Mexicen, Puerto Rican, etc.)
1 YES 2 NO Specify: FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: ВУ White 3 X Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) COMPLET Flementary/Secondary (0-12) College (1-4 or 5 +) 8 Years Label Checker Cup Corporation 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Gussie Schnell Alfred Leucht notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 0 8505 Philadelphia Road Baltimore, MD 21237 George E. Rose pe 20e. METHOD OF DISPOSITION

***Display="2" | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | Below | B 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Cedar Hill Cemetery 11/14/95 Brooklyn, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Duda-Ruck funeral Home of Dundalk, Inc. 1 Bible oline 7922 Wise Ave. Dundalk, MD 21222 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition resulting in death) traumatic event, asperation CERTIFICATION Sequantially list conditions, if any, leading to immediate DUE TO (OR AS A cause. Enter UNDERLYING CAUSE (Disease or injury other TO (OR AS that initiated evanta reauiting in death) LAST 0 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 28. PLACE OF DEATH (Check only one. 25. WAS CASE REFERRED TO MEDICAL item EXAMINER? HOSPITAL OTHER 2 ER/Outpatient 3 🗆 DOA the 27 MANNER OF DEATH 28e. DATE OF INJURY (Month, Dev. Year) 286. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY 28e. PLACE OF INJURY -- At home, ferm, street, fectory, office 281. LOCATION (Street end Number City on Town, State) Suicide 28 is 1 8 Could not be determined COMPLETED 4 Homicide J THE HOSPING.
TO THE FUNERAL DIRECTOR MICHORAL DIRECTOR MICHOLIC PROPERTY IN THE PROPERTY OF item 29e, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end 29b. SIGNATURE AND TITLETON CENTIFIE BE 2

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within A low limit ath. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competer the competer that the competer of the control of the	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitled at once.
The roof offer	ation, or removal.	the medical exa
e be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and come mention for the first within 72 hours after death with the State Dent, or Health and Mental Hydiene prior to burial, cremation, or removal.	traumatic event,
the death certificat	y the attending physical property of Mental Hygiene p	injury, or other
e law requires that	has been signed by Dept. of Health an	1 23 shows any
NG PHYSICIAN: Th	ter this certificate ath with the State	marked, or item
TAL OR ATTENDIA	RAL DIRECTOR: At 172 hours after de	T. It item 28 is r
TO THE HOSP	TO THE FUNE	IMPORTANT

DIVISION OF VITAL RECORDS, P.O. BOX 6876

STATE OF MARYLAND / I	DEPARTMENT OF	HEALTH AND	MENTAL	HYGIENE
CE	RTIFICATE O	F DEATH		REG NO

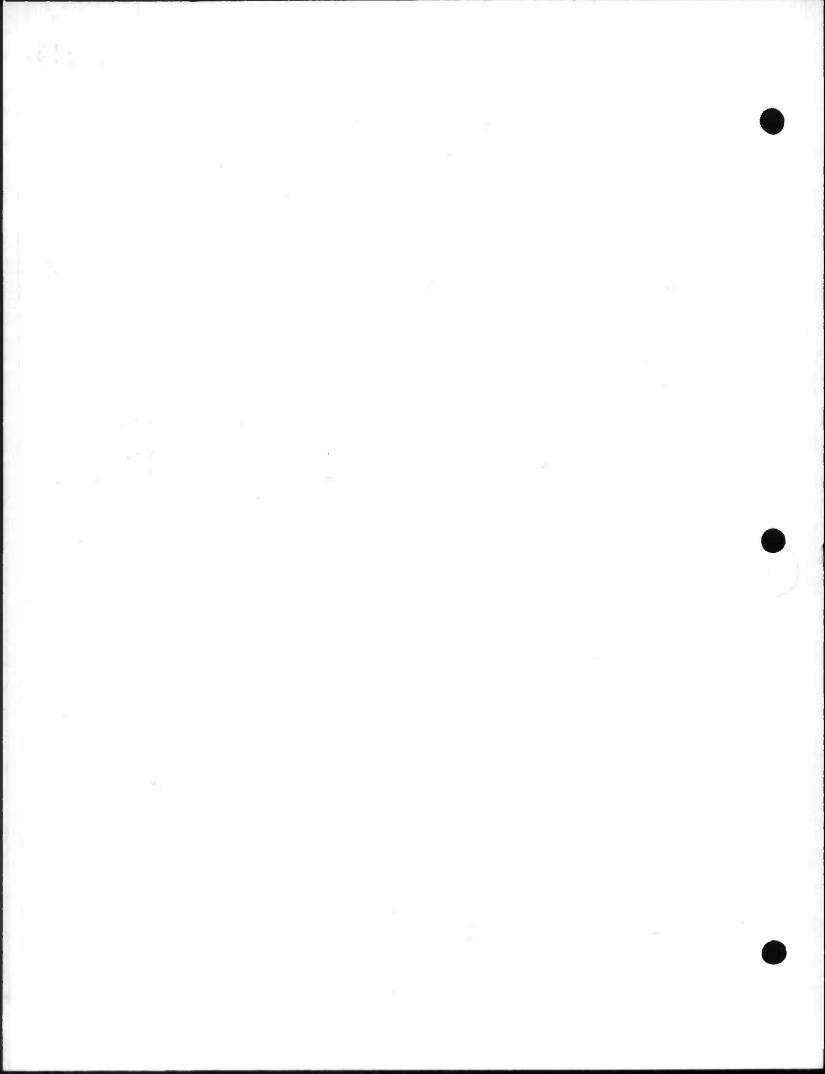
	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	Imogene Cav	rie Sojka				November	10,1995	3:55 рм			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In	r yrs. lest birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTI	IPLACE (State or Foreign			
	214 ← 38 ← 5950 9a. FACILITY NAME (N not institution, give	1 M 2 KF 70	YRS.	CITY TOWN O	HOURS MIN.	Sept. 30,		st Virginia			
TOR	98. FACILITY NAME (N not inetitution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 97. COUNTY OF DEATH 97. COUNTY OF DEATH 98. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH N/A										
<u>n</u>	10e. STATE 10b. COUNT	TY	10c. CITY, TO	WN OR LOCATI	ON			10d. INSIDE CITY			
FUNERAL DIRECTOR	Maryland 100. STREET AND NUMBER	N/A		_	Baltimor	e City		LIMITS? 1 XYES 2 NO			
RA	714 South Milton	411212112		101.	212	0.1	united	100			
¥ I	11. MARITAL STATUS		US ADMED	12 WAS DECI				E — American Indian,			
	1 News Married 2 V Married FORCES? 1 YES 2 K NO If yes, specify Cubsn, Maxican, Puerto Ricen, atc.) Black,							k, Whits, stc.			
BY	3 Widowed 4 Divorced	IF 125, GIVE WAR OR DA	ics	I I I TES	XX NO Specify	<i>'</i> :	Spec	white			
COMPLETED	t5. DECEDENT'S ED (Specify only highest grad	UCATION	18e. DECEDENT'S USL	AL OCCUPATIO	N	16b. KIND OF BUS					
ᇤ	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use rel	ired.)	it or working						
릴	6 Years		Home	Maker		Ou	n Home				
Ö	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden	Surname)				
BE (Elby Ralston				Carrie	. Jones					
10	19s. INFORMANT'S NAME (Type/Print)					Route Number, City or Town					
	Paul E. Sojka,		714 So	uth Mi	lton Ave	. Baltimo	re, Mary	land 21224			
	20a. METNOD OF DISPOSITION 1 Burisi 2 Cremation 3 Res 4 Donation 5 Qther (Specify)	moval from Stata	PLACE AND DATE OF D stery, cremetory, or other LCTED HT.	SPOSITION (Ne	us Cem.1	1/13/95 D	cation - city or to	own, Stats			
	21. SIGNATURE OF BUNERAL SERVICE L	JCENSEE O		22. NAME AN	D ADDRESS OF FA	eral Home	101	01 7			
	Tregon	E Kend		7922	wise Ave	. Dundalk	, MD 21	222 Inc.			
	23. PART I. Enter the disesses or	complications that caused	the death. Do not	entar the mo	da of dying, suci	h as cerdiac or respi	ratory srrest,	Approximate Interval Between			
	shock of their fellure. List only one ceuse on eech line. IMMEDIATE CAUSE (Final										
	disease or condition resulting in death)										
		OUE TO (OR AS A	CONSEQUENCE OF):	minutes							
Z	Sequentially list conditions	Pnuemonia						9 days			
Ĕ	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	Cerebral vaso	cular acci	dent				9 days			
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
		d									
AL (PART II. Other significant condition	ons contributing to deeth bu	it not resulting in t	ne underlylng	csuse given in	Pert I. 24s. WAS AN		D. WERE AUTOPSY FINDINGS			
5	Huntington's che	orea, hyperter	sion, cor	onary	heart	PERFOR		AWAILABLE PRIOR TO COMPLETION OF CAUSE			
	failure, atrial							DF DEATH?			
5	DID TOBACCO USE CON	TRIBUTE TO CAUSE OF	F DEATH YES	□ NO ☑	UNCERTAIL	N D					
¥	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATN (
PHYSICIAN: MEDIC	EXAMINER? 1 TYES 2 NO	HOSPITAL: 1 N Inpetient 2 ER/Outpi		THER: Nursing Nom	s 5 Residence	8 Other (Specify)					
Ξ	27. MANNER OF DEATN	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	F 28c. INJ	JRY AT	28d. DESCRIBE HOW I	NJURY OCCURED				
ВУ	1 X Natural 5 Pending 2 Accident Investigation		INSON		RK7 'ES 2 NO						
	3 Suicide 8 Could not be	28s. PLACE OF INJURY	— At home, farm, stree	t, tactory, office		28f. LOCATION (Street		Route Number,			
国	4 Nomicide determined	bonding, etc. (Speci	, , ,			City or Town, State)					
COMPLETED	29s. CERTIFIER (Check only 1 X CERTIFYING PNY	SICIAN: To the best of my knowle	edgs, dsath occurred a	t the time, data	and place, and due	to the cause(s) and mar	oner as stated.				
M		NER: On the basis of examination						s) and manner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFI	DER (29c. LICENSE NUI			D (Month, Day, Year)			
BE	Carolin Hou				9600			ber 13,1995			
임	30. NAME AND ADDRESS OF PERSON W		ATN (ITEM 27) (Type, Prii	nt) ,	-						
	Carolyn Houk			Jonns		Bayview M					
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN/	NTURE	4940	astern	avenue. Ra	Trimore.	MD 21224			
	NUV1 11995	the development	A								

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate being	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and	be filed within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to b

	FOR 1 - STATE REGISTRAR	STATE OF F	MARYLAND C	/ DEPAR	TMENT OF	HEAL F DE	TH AND	MENTAL	HYGIEN	E	J	04114
	1. DECEDENT'S NAME (First, Middle, Last)	Rac	hel Mar	ie Sh	affer			MONTH	of DEATH DA		YEAR	3. TIME OF DEATH 11:42 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le	ast birthday)	IF UNDER 1 YEA	IR IFU	NDER 24 HRS.	7. DATE C	OF BIRTH	0, 1.	6. BIRTHP	LACE (State or Foreign
	N/A	1 🗆 M 2 💢 🌾	N/A	YRS.	MONTHS DAY	8 HOU		NOV.	Day, Year)	995	Country)	uland
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOV		CATION OF DE		0, 1		TY OF DE	
DIRECTOR	Franklin Square	Hospita	Ro	ssvi	lle			Ba	ltimo	re		
E C	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									IOD. INSIDE CITY		
	Maryland 100. STREET AND NUMBER	N/A					Balti	imore	City			LIMITS? YES 2 NO
FUNERAL						10f. ZIP (CODE			10g. CITI	ZEN OF WH	IAT COUNTRY?
Ä	6907 East Baltimo							224			ted S	States
F	11. MARITAL STATUS 1) Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED NO	13. WAS	DECENDER	NT OF HISPAN Cuban, Maxica	NC ORIGINS	(Specify Yes	or No-	14. RACE - Black,	- American Indian, White, stc.
B	3 Widowed 4 Divorced	IF YES, GIVE V	WAR OR DATES			rES 2 D					Specify:	White
E E	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(4	Give kind of v	USUAL OCCUP		rorking	16b.	KIND OF BUS	SINESS/IND	USTRY	
ONCE.	Elementary/Secondary (0-12)	College (1-4 or 5	+)	e. Do NOT us	ve retired.)					11/4		
once.	N/A 17. FATHER'S NAME (First, Middle, Lest)			- 1	V/A	100	WOTHER'S NA	NOT 151-1 11		N/A		
E G	Mark Shaffer						imber	-,		,	2010	
	19a. INFORMANT'S NAME (Type/Print)		11	9b. MAILING	ADDRESS (Stre			_				
notified TO BI	Mark Schaffer				East E							MD 21224
2	20a. METHOD OF DISPOSITION		20b.PLACE	AND DATE	OF DISPOSITION	/Name of		DATE	20c. LO	_		
Ē	1 💢 Burial 2 🗆 Cremation 3 🗆 Rem 4 🗆 Donation 5 🗆 Other (Specify)		_ Vak I	awn (emeter	y 1	1/14/	1995	Ва	ltimo	re, I	MD
amine	21. SIGNATURE OF JUNERAL SERVICE LIC	ENSEL)		Dudo	-Ruc	ek Fun	CHITY				
ě _	Mega 2	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222										
e medical examiner must be	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiec or respiratory arrest, interval Between Onset and Death											
or other traumatic event, the	disease or condition resulting in death) a. Pulmonary Insufficiency DUE TO (OR AS A CONSCOUENCE OF):											
2 Z					,							
TO I	Sequentially list conditions, fi any, leeding to immediate b. Severe Prematurity DUE TO (OR AS A CONSEQUENCE OF):											
S E	cause. Entar UNDERLYING CAUSE (Disease or Injury	D										
or other traumatic	that initiated events	DUE TO	(OR AS A CONSE	OUENCE OF	7):							
P. H	resulting in death) LAST											
injury.	PART II. Other significant condition	s contributing to	deeth but not	resulting I	n the underly	/ing ceu	se given in	Part I.			24b. V	/ERE AUTOPSY FINDINGS
es any li									PERFOR		C	MAILABLE PRIOR TO COMPLETION OF CAUSE
ME								_		6		F DEATH?
	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	ATH YE	S NO	⊠ U	NCERTAIN	1 D				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEAT	H (Check only a	ne)						
YSI	1 TES 2 XNO	1 X Inpatient 2	ER/Outpatient	3 🗆 DOA	OTHER:	lome 5	Residence	6 🗆 Other	(Specify)			
marked, or BY PHY	27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D		28b. TIMI	URY	INJURY A' WORK? YES		26d. DE\$0	CRIBE HOW IN	JURY OCC	CURED	
28 is FED	3 Suicide 6 Could not be detarmined	28s. PLACE O building,	F INJURY — At he atc. (Specify)	ome, farm, s	treet, factory, o	ffice		281. LOCA City of	TION (Street a Town, State)	nd Number	or Rural Rou	ite Number,
E	29a, CERTIFIER 1 [X] CERTIFYING PHYSI	CIAN: To the heat of	an kanuladas d		4 - 4 4 4 - 4 - 4							
ANT: If ite	(Check only one) 2 MEDICAL EXAMINE											and manner as stated.
PORT	296. SIGNATURE AND TITLE/OF CERTIFIER 29d. DATE SIGNED (Month											
₽ ₽	36. NAME AND ADDRESS OF PERSON WHI	COMPLETED CAUS	SE OF DEATH-(TE	M 27) (Type,	Print)		D429	UJ		./	10/	()
	Gregory Scheam	V	Penn A			timo	ore, M	D 21	236			

22. REGISTRARY SIGNATURE

31. DATE FILED (Month, Day, Year)
NOV1 7 1995



24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within all frounds after death. Page 6 may be retained by the intending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF N		DEPAR	ICATE		EALTH DEAT		MENTAL H	YGIEN EG. NO	E			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH	av	VEAR	3. TIME OF DEATH	
	Charles E.	Smith,							Noveml	ber	16, 1	1995	5:55 A.	М
	MONTHS DAYS HOURS MIN. (Month, Day, Year)									PLACE (State or Foreign				
	219-32-6914	YRS.	ah OITY	701181 0	NTAGO A CA	N OF DE		17,				_		
Œ	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 1136 Newcomb Way Baltimore N/A												SAIR	
6	RESIDENCE OF DECEDENT							-				N/A		
E	10a. STATE 10b. COUNTY Maryland				Y, TOWN		ION						10d. INSIDE CITY LIMITS?	
0 7	10e. STREET AND NUMBER	N/A		В	altir	_	. ZIP CODE	:			10¢ CIT		1 X YES 2 NO	_
RA	1136 Newcomb Way					1		205				u.s.		
FUNERAL DIRECTOR	11. MARITAL STATUS		T EVER IN U.S. ARM				ENDENT O	F HISPAN	IIC ORIGIN? (S		s or No—	14. RACE	- American Indien, White, atc.	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W		5			2 NO		n, Puerto Rice: /:	n, etc.)			y: White	
	15. DECEDENT'S EDUC	ATION	18a DEC		USUAL O	CCUPATIO	NA .		185 KIN	D OF BU	SINESS/IN	1	***************************************	_
ETE	(Specify only highest grade	completed) College (1-4 or 5 -	(Giv	e kind of	work done ise retired.)	during mo	st of working	g	100. 101	0 00	3111L30/111	DOSTILL		
1PL	12th grade	College (1-V of 5		Sal	esmar	1			1	Bake	ry Co	ompan	y	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)								ME (First, Midd		Surneme)			Т
BE	James L. Smith								1. Har					_
10	190. INFORMANT'S NAME (Type/Print) Sandra C. Smith (W	11/01							Route Number, (timore	,			205	
	204 METHOD OF DISPOSITION		20b. PLACE A					buc	DATE	v		- City or Ton		
	1 N Burial 2 Cremetion 3 Remo	ival from State	Glen H	ave	n Mer	n. Po	ark 1	1/20	0/95	Gle	n Bw	rnie,	Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	nyax /							eral H					
	4/11/5/1								ane, B		more.	. MD	21213	
	23. PART i. Enter the diseases, or c			th. Do									Approximate	-
	ahock, or heart failure. List only one ceuse on each line. Interval Batween Onset and Death													
	disease or condition resulting in deeth) 8. CONGCEPTIVE / JESMY FINLING / 120M													
_	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury) DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):											1. T4R	5	
CERTIFICATION												1 0	_	
S														
TE	that Initiated events	DUE TO	(OR AS A CONSEO	UENCE C	OF):									
EB		1											1	
CAL	PART ii. Other aignificant condition					nderlyin	g cause	given in	Part I. 24		AUTOPSY	24b.	WERE AUTOPSY FINDING	S
DIC	DIABE	TES 1	nezai	05	*				1	YES	2 200		COMPLETION DF CAUSE OF DEATH?	
MEDI							7		_/				1 TES 2 NO	
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 25. PLACE OF DEATH (Check only one)													
PHYSICIAN:	EXAMINER?	HOSPITAL:	☐ ER/Outpetient 3		OTHE		n 5 6	paldanca	6 🗆 Other (S	nac(b)				
HX	27. MANNER OF DEATH	28e. DATE Of	F INJURY	26b. TII		26c. IN.	JURY AT		28d. DESCR		INJURY O	CCURED		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(IMDINI), E	Jay, Iour/		M	1 🗆		NO						
	3 Suicide a Could not be	26e. PLACE (building	OF INJURY - At hor , etc. (Specify)	me, ferm,	street, fee	ctory, offic	:•			ON (Street own, State		er or Rural F	Route Number,	
COMPLETED	An- ASSTRICTED :		-											_
MPL	(Crieck only		f my knowledge, der) and meaner as attend	
00		n. Oil the base of	examination and/or i	riveatigat	ion, in my	opinion, c				a piace, e			e) end manner ea stated.	
29c. LICENSE NUMBER 29d. DA								. /	(Month, Day, Year)					
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAL									1	., , ,	6/95	-
	Charles Hoesch,	9712 Be	elair Roo	ıd,	Balt	imor	e, Mo	vryl	and 21	236				
	31. DATE FILED (Month, Day, Year)		AR'S SIGNATURE											
	NOV1 71995 9	Why attended	MANAGE TO											

examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
le funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
r death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp

FOR TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - REGISTRAR				CERT	IFICAT	E O	DEA	TH		REG. NO	_		
1. DECEDENT'S NAME (First,	Middle, Last)									OF DEATH	-		3. TIME OF OEATH
Helen	Mary		Sch	midt					NOV	. 14	14 1995		6:00p M
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In	yrs. lest birthd	sy) IF UND	ER 1 YEAR	IF UNDE	A 24 HRS.	7. DATE	OF BIRTH		8. BIRTH	IPLACE (State or Foreign
213-52-5879		1 🗆 M 2 🔀 F	96	YRS	MONTHS	DAYS	HOURS	MIN.	Marc	ch 2,	1899	Countr	
9a. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CI	ry, Town	OR LOCAT	ION OF D		21 27 .		INTY OF D	4
Stella Mari	s Host	oice			T	owso	n				Bal	Ltimo	re County
RESIDENCE OF DEC	EDENT							-					
10a. STATE	10b. COUNT	•			CITY, TOWN		ATION						10d. INSIDE CITY LIMITS?
Maryland	Barti	imore Cou	nty		owson								1 TYES 2 NO
10e. STREET AND NUMBER						19	of. ZIP COD				_		VHAT COUNTRY?
2300 Dulane	y Vall						2120)4			U.S.	Α.	
11. MARITAL STATUS 1 Never Merried 2	Mountaid	12. WAS DECEDEN FORCES? 1			13		CENDENT (17 (Specify Yea	or No-	14. RACE Black	E — American Indian, k, White, etc.
3 X Widowed 4 Divo		IF YES, GIVE W					S 2 XNO			, mount, oran,		Wni	
	EDENT'S EDU	CATION	1	16e. DECEDEN	T'e Hellal	0001104	7004		1.70				.te
(Specify only	highest grade	completed)		(Give kind	of work don	e durina r		ing	160	. KIND OF BU	SINESS/IN	DUSTRY	
Elementery/Secondary (0 5th Grade	-12)	College (1-4 or 5 +	·)	Homema	aker	•				Own Ho	nme		
17. FATNER'S NAME (First, Mi	iddle, Last)			1101110111			18 MOT	HED'S NA	ME /First	Middle, Maiden			
	nown	Deiter						rgare		Unkn		Un	known
19e, INFORMANT'S NAME (7)	rpe/Print)			19b. MAIL	ING ADDRE	SS (Street				ber, City or Tow	n State 7		
Helen Jarbo										<i>l</i> aryla			
20a. METNOD OF DISPOSITI			20h I	PLACEANDDA		_		LOWB	DAT			City or To	aun State
1X Buriel 2 Crematio		oval from State						cv 1					Maryland
21. SIGNATURE OF FUNERAL		CENSEE	^	4	2:	. NAME	AND ADDRE	SS OF FA	CILITY			,	2
W)	m=	\ ()	2->			C. M						
	Δ	Pops	1										yland 21206
23. PART I. Enter the di ahock, or he	sert failure.	complications that List only one cau	t caused se on ea	tha death. D ch lina.	o not ante	er tha m	oda of dy	ing, auc	h az care	diac or respi	ratory ar	reat,	Approximata Interval Between
IMMEDIATE CAUSE (Fin	al	0 8											Onset and Daath
disease or condition resulting in death)	→			cler		Cai	dio	vasc	cula	r Dis	ease	9	10 years
		DUE TO	(OR AS A	CONSEQUENCE	E OF):								
Sequantially list conditi	ona.	b									-		
If any, leading to immed cause. Enter UNDERLY!	diata	DUE TO	(OR AS A	CONSEQUENCE	E OF):								
CAUSE (Disease or Inju		c	(OR AS A (CONSEQUENCE	OE:								-
that initiated events resulting in death) LAS	ī		(01110111		. 0. ,.								İ
<u></u>		d											
PART II. Other algnifica	nt condition	a contributing to	daath bu	t not raaultir	ng In the u	ınderlyi	ng cause	given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
										1 YES 2			CDMPLETION OF CAUSE DF DEATH?
													1 TYES 2 NO
DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF	DEATH	YES 🗆	NO [JUNG	CERTAI	N N				
25. WAS CASE REFERRED TO				S. PLACE OF D									
EXAMINER?		HOSPITAL:	STOUTH	tient A 🗆 DO	OTHE 4 DON		me 5 🗌 R	esidenca	8 🗆 Othe	r (Specify)			
27. MANNER OF OEATH		29s. DATE OF	NJURY WW.	28b.	TIME OF	28c. If	JURY AT			CRIBE HOW I	NJURY OC	CURED	
	Pending nvestigation		· · · · /		INJURY M		YES 2	NO					
a I'll durates	Could not be	28e. PLACE OF	INJURY -	At home, fen	m, street, fa	ctory, off	ice		28f. LOC	ATION (Street 8	nd Numbe	r or Rural F	Route Number,
	telermined	aunapro.	etc. Epecit	10					City	or Town, State)			
29s. CERTIFIER	FYING PHYSI	CIAN: To the best of	m knowie	day doub oo	umad at the	Alma da		and do	4- 4				
) and manner as stated.
29b. SIGNATURE AND TITLE				-	and any	Spilleri,	-	9					
AND STURMS ONE AND STILL	OF CHILIPPED						290/LI	ENSE NUI	MBER 500	6	29d. DAT		(Month, Day, Year)
30. NAME AND ADDRESS OF	BEOM WA	O COMPLETED CALL	E OF DEAT	IN /ITEM AT /	Con Delen				- /			7	
						. 77	. 1 1 -			m		ME	21204
Eddie Nak		M.D.		0 Dul	lane	/ V 8	тте	y .RC	oad,	TOWS	on,	MD	21204
NOV4 7100		/ //		M									

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DIVISION OF VITAL RECORDS, P.O. BOX 6876

1	-	FOR STATE REGISTRAR	
E	1. D	ECEDENT'S NAME	(Fir

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

_	TIEGIS TIMIT			OLITTI	IOAIL	01	CLAIII	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2, DATE OF OEATH MONTH DA	Y	WE	3. TIME OF DEATH
	Marie	Treca	nnelli	Ĺ	N			Nov. 13, 1995 11:05			11:05 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rs. last birthday)	IF UNDER 1		IF UNDER 24 HRS.	, 7, DATE OF BIRTH (Month, Day, Year)			LACE (State or Foreign
	212-09-7425	212-09-7425 1 March 25					(Month, Day, Year) March 25,	1919	Country, Mai	yland	
	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY,	TOWN (OR LOCATION OF DE	ATH	9c. COU	NTY OF DE	ATH
۳ ا	Greater Baltim	ore Medi	cal Ce	enter	тс	owso	on		Ва	ltimo	ore
Ĕ I	RESIDENCE OF DECEDENT	010 110 41									
DIRECTOR	10a. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OF	R LOCA	TION				10d. INSIDE CITY LIMITS?
	Maryland Balt	imore			Dunda	alk					1 - YES 2 X NO
4	10e. STREET AND NUMBER					10	f. ZIP CODE		10g. CIT	IZEN OF WI	HAT COUNTRY?
E	7544 Holabird	Ave.					21222			U.S.A	Α.
FUNERAL	11, MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.	S. ARMED				IIC ORIGIN? (Specify Yes	or No—	14. RACE	- American Indian,
	1 Never Married 2 X Married	FORCES?			1	Yea, sp	3 2 X NO Specify	n, Puerto Rican, etc.)		Specify	White, etc.
BY	3 Widowed 4 Divorced										White
	15. OECEDENT'S EDUC (Specify only highest grade	CATION completed)	16	a. DECEDENT'S				16b. KINO OF BUS	INESS/IN	DUSTRY	
91	Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT u	se retired.)		•				
를	8 yrs.			Home M	laker			Own H	Iome		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)						18. MOTHER'S NA	ME (First, Middle, Malden	Surname)		
BE	Albert Mox						Barbar	a Do	rber	t	(63)
	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street	and Number or Rural I	Route Number, City or Tow	n, State, Zi	p Code)	
2	Anthony Trecannel	li		Same	as ‡	#10					
	20a. METHOD OF DISPOSITION		20b. PL	ACE AND DATE	OF DISPOSI	TION (N	ame of	DATE 20c. LO	CATION -	City or Tow	rn, Stata
	1 No Burial 2 ☐ Cremation 3 ☐ Rame 4 ☐ Donation 5 ☐ Other (Specify)	oval from Stata	Ga1	ry, cremetory or c rdens c	Fai	ith	Cem. 11	/16/95 Ove	rlea	, Mai	cyland
	21. SIGNATURE OF FINERAL SERVICE LIC	ENSEE		_	22. N	NAME A	ND ADDRESS OF FA	CILITY			
	Dregon	EK	en S	2				eral Home			
	23. PART I. Enter the Assass, or o	complications the	it caused th	e deeth. Do							Approximate
	shock, or heart failure.	List Dniy Dne ca	use Dn each	ine.							Onset and Death
	disease or condition	META	74770	£	Ann	1 1	BIL CAY	21 Many	N3	ck	6 MARATI
	resulting in death)	a. DUE TO	(OR AS A CO	ONSEQUENCE O	F):						01-4711
-	- Com Anadyl CBC, CARRIAMMA NECK DAMAGA MANY THAT										
<u>ō</u>	disease or condition resulting in death) a. METASTATIC SQUAMOUS CELL CARCINOMIA NECK 6MONTIC DUE TO (OR AS A CONSEQUÊNCE OF): Sequentially list conditions, if any, leading lot immediate only. South the following list of the following list in the following list of the following list										
ķΙ	Cause, Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A CONSEQUENCE OF):									
F	resulting in death) LAST	4									
8											
A									WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
EDICAL	DIABETES ME		-			1 _ YES 2	MO		COMPLETION DF CAUSE OF DEATH?		
ME							_				1 _ YES 2 _ NO
	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF	DEATH Y	ES 🗆 N	10 E	UNCERTAIL	1 D			
ΧI	25. WAS CASE REFERRED TO MEDICAL		26.	PLACE OF DEA	TH (Check o	only one)				
S	EXAMINER?	HOSPITAL:	ER/Outpatie	ent 3 🗆 DOA	OTHER		ne 5 🗆 Residence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE O		28b. TIR			JURY AT	26d. DESCRIBE HOW I	NJURY O	CURED	
	1 Nstural 5 Pending	(WORR), I	Day, Year)	IN	JURY M		YES 2 NO				
ВУ	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY At hom				atreet, facto	ory, offic	ca	26f, LOCATION (Street of	and Numbe	er or Rural R	oute Number,
COMPLETED	4 Homicide Getarmined	bullding	, atc. (Specify)					City or Town, State)			
9	29a. CERTIFIER										
d M	(Check only										
<u> </u>	2 MEDICAL EXAMINE	H: On the basis of a	ixamination at	nd/or investigati	on, in my of	pinion,	death occured at the	time, data and placs, an	id dus to 1	the cause(s)	and manner as atsted.
BE	BIGHATURE AND TITLE OF CERTIFIES	1					29c. LICENSE NUI	MBER	-		(Month, Day, Year)
	Then Moller	de					125/	53	1	1-14	-95
8	35 NAME AND ADDRESS OF PERSON WH	O COMPLETED CAL									
-	John Saunders, M				cles	Str	eet Suit	e 200 Ba	Ltimo	ore,M	d.
	31. DATE FILED (Month, Day Year) Va	32 REGISTR	AR'S SIGNATI	JRE							
- 1	MONT (1992 Am	UN distant	reads.	-							

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D 21215-0020	And her needs to the need to be
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BALTIMORE,	Boon & man by setting
BALT	house after doubt
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DIVISION OF VITAL RECORDS, P.O. BC

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the brinal-transit narmit pages 1.2.3 servain
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTI	MENT OF H	IEALTH AND	MENTAL	HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		YEAR :	3. TIME OF DEA	ГН
	ROYLAND C.		WILSON	I		NOVE		, 199		9:55	A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs.	MC	UNDER 1 YEAR	IF UNDER 24 HRS.		Dey, Year)		BIRTHPI Country)	LACE (State or Fe	oreign
	217-34-4451 9e. FACILITY NAME (If not institution, give str	7 3/	YRS.				7,1			imore	
œ					OR LOCATION OF D	EATH		9c. COUNT	TY OF DEA	ATH	
CTO	THE JOHNS HOPKIN	IS HOSPITAL	1 1	BALTIMO	RE CITY				N /	A	
IRE	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ION				1	IOd. INSIDE CITY	,
٦	Maryland 100. STREET AND NUMBER	N / A	Bal	timor						YES 2	NO
FUNERAL DIRECTOR		1		101	. ZIP CODE			10g. CITIZI	EN OF WH	IAT COUNTRY?	
SNE	6832 McClean Bi	12 MBS DECEDENT EVER IN U.S.	ARMED	13 WAS DEC	21234 ENDENT OF HISPAI		(Canally Van	US		- American Indi	
F	1 Never Married 2 Married	FORCES? 1 YES 2	NO	If yes, sp	city Cuban, Maxics	an, Puerto R	(Specify Yea (can, atc.)	or No-	Black, Specify:	White, etc.	en,
Э ВУ	3 Widowed 4 Divorced			1	T A TTO ODOG	.,,.				lack	
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of	completed)	DECEDENT'S US (Give kind of work life. Do NOT use n	done during mo	ON st of working	16b,	KIND OF BUS	SINESS/INDU	STRY		
P	Elementary/Secondary (0-12)	College (1-4 or 5 +) N / A		,			-				
MO	17. FATHER'S NAME (First, Middle, Last)	N/ A	Pain	ter	16. MOTHER'S NA	MF (First M		intir	ıq		-
BE C	Cosy Wilson						nowde				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a	nd Number or Rural				code)		
-	Valerie Wilson		7049 M	cClear	n Blouv	ard.	Balto	. bM.c	212	34	
	20a METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov	val from State 20b. PLAC cemetery,	CEAND DATE OF C	place)			20c. LO				
	4 Donation 5 Other (Specify)	- NS	Mt	Zioi	D ADDRESS OF FA	11-1	1 Ba	ltimo	re,	Md.	
	1 0 0 ha	11-0.	/			C	arlto	on C.	Do	uglass	5
_	23 PADT i Enter the diseases or an	- house	u	1701	McCull	oh S	t.,Ba	alto.	, Md		
		iat only one cause on each il	ne.	enter the mo	de of dying, suc	ch se cerdi	sc or reapi	ratory srre	nt,	Approxim	etween
	iMMEDIATE CAUSE (Finel disease or condition	Macontonia F	20 20 1000							Onset and	Death
	resulting in death)	DUE TO (OR AS A CON!	SEQUENCE OF):							7094	S
Z	disease or condition resulting in death) Neutric Protection 70 Due to (or as a consequence of): Ex Sanguin at a consequence of the conditions, and the conditions of the co								1 ho	/	
AT	If sny, leading to immediate cause. Enter UNDERLYING	If any, leading to immediate									
S	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONS	SEQUENCE OF:							-	
CERTIFICATION	resulting in deeth) LAST									j	- 1
	PART II. Other significent conditions	contribution to death but no	A manufalmo I - A			- I				1	
CAL	PART II. Other agrinicent conditions	contributing to deeth but no	t resulting in t	ne underlying	csuae given in	Part i.	24a. WAS AN PERFOR		A	MAILABLE PRIOR	то
ED						-	1 X YES 2	□ NO	٥	OMPLETION OF C	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DE	ATH YES	Пиоп	UNCERTAIL	N D			1	☐ YES 2 🕱 I	10
X A	25. WAS CASE REFERRED TO MEDICAL	26. PL	ACE OF DEATH (OTTOERIAN						
rsic		HOSPITAL:		THER: Numbing Home	s 5 Residence	6 Other	(Specify)				
PH	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME O		URY AT RK?	28d. DEŞ0	CRIBE HOW IF	JURY OCCU	RED		
B	2 Accident Investigation				ES 2 NO						
03	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, stree	t, tectory, office			TION (Street a Town, State)	nd Number or	Rural Rou	ite Number,	
COMPLETED	29a. CERTIFIER	IAN). To the heat of my heavy to do				01000000	La constant	000			
MP		IAN: To the best of my knowledge, On the basis of examination and/o								nd menner se e	eted
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI						
B	Kelly Sile Interes			- 1	N4487		ŀ			fonth, Day, Year)	į
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (I	TEM 27) (Type, Prin	t)				14011	crocr	6.1995	
	Kelly Gobo, Tower 11	10, 601 N. Wolfe	St. Balt	inore, M	0 21287	L					
	NOV1 71995	32. REGISTRAR'S SIGNATURE		` `							\neg
	The CERT Tron	. Studentales									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

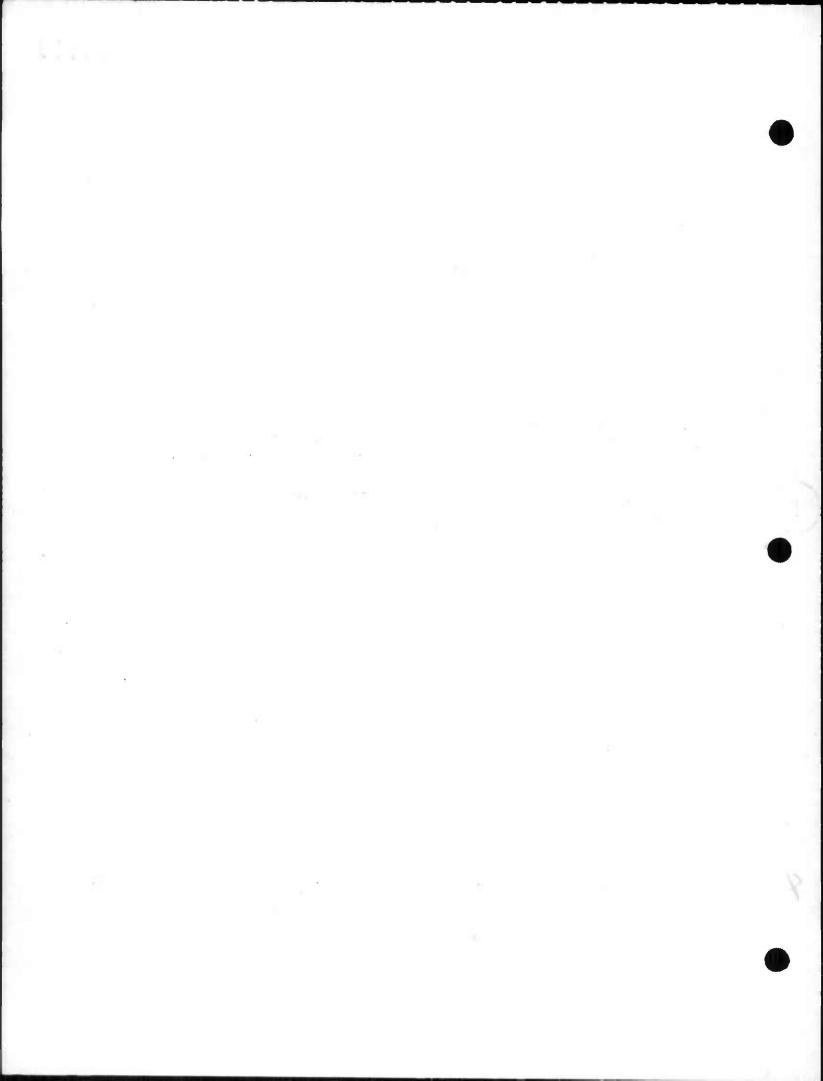
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Jeffres 31. DATE FILED (MORTH, Day, Year) NOV1 71995

								9	0 0)4/12
	FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR				MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. Tr	ME OF DEATH
- 8	Esma /	2 1,1	h:40				WONTH DI	199	EAR	12:30 PM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	In yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			E (State or Foreign
	215-22-0442	1 M 2 X F 7		MONTHS	DAYS	HOURS MIN.	(Month, Day, Year)		Country)	
- 1	9e. FACILITY NAME (If not institution, give st			AL OFFY	TOWN	R LOCATION OF DE	June 22,19	92U Ma	aryla	nd
or		eet end number)					AIN.			
0	St. Agnes Hospital			Balt	imor	e		Baltin	nore	
E	10e. STATE 10b. COUNTY		10c, CI	Y, TOWN O	R LOCATI	ION	•			INSIDE CITY
DIRECTOR	Maryland N	/A	RAI	LTIMO	DE					LIMITS? YES 2 NO
	10e. STREET AND NUMBER	121	DAI	311110	_	ZIP CODE		10g. CITIZEN	45	
FUNERAL	3800 West Belveder	a Azzamiia (A-	. 011)			21215		TI C	A	
N.	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13.3			IIC ORIGIN? (Specify Yes	U.S.A		merican Indian,
	1 Never Married 2 Merried	FORCES? 1 YES	2 NO	1	f yes, spe	city Cuben, Mexica	n, Puerto Ricen, etc.)		Black, Whit	te, etc.
ВУ	3 Widowed 4 Divorced	IF TES, GIVE WAR OR DA	AI ES	'	I L TES	2 NO Specify	<i>y</i> :		Specify:	White
Q	15, DECEDENT'S EDUC	ATION	18e. DECEDENT'S	USUAL O	CCUPATIO	N.	16b. KIND OF BU	SINESS/INDUS		
E	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of life. Do NOT L	work done (se retired.)	during mos	st of working				
PL	10th grade	College (1-4 of 5+)	Waitı	2000			Restau	irant		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Walti	. 655		18. MOTHER'S NA	ME (First, Middle, Maiden			
	Paul C. Diven					Maunott	a Burrows			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	AOORESS	Street ar		Route Number, City or Tow	n, State, Zip Co	ide)	
5	Barbara D. Borgvon	(Daughter)	5247 N	Nelso	n Av	e.; Balt	imore, Man	ryland	2121	5
	20e. METHOD OF DISPOSITION	20b.	PLACE AND DATE	OF DISPOS	ITION (Ne	me of	OATE 20c. LO	CATION — City	or Town, S	itate
	1 Burlel 2 X Cremetion 3 Remo	eval from State	etery, cremetory or eenmount	Cre	mato	ry 11/15	/95 Balt	imore,	Mary!	land
	21. SIGNATURE OF FUNERAL SERVICE LIC			22	NAME AN	O ADDRESS OF FA	CILITY			
	111	111					eral Home		100 0	
	41	M		_			ane, Balti			
	23. PART I Enter the diseesea, or of ahock, or heert fallure.			not enter	the mo	de of dying, auc	h aa cardiac or resp	iretory arrest	19	Approximate Interval Between
	IMMEDIATE CAUSE (Finel		D			,				Onset and Deeth
	disease or condition reaulting in deeth)	a,/	/ nee	nin	OU	10				4 days
		DUE TO (OR AS A	CONSEQUENCE	DF):		ia of Lu				, /
Z	Sequentially list conditions,	o. Cay	cono	ma	_ 0	st 20	ing			(year
TIC	If any, leading to immediate	OUE TO (OR AS A	OUE TO (OR AS A CONSEQUENCE OF):							
2	CAUSE (Disease or Injury	D-								
CERTIFICATION	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE (>F):					i	
H		d								
	PART II. Other algoliticant condition	s contributing to deeth b	out not resulting	In the ur	nderlylng	g ceuse given in				E AUTOPSY FINDINGS
MEDICAL							PERFO		COM	LABLE PRIOR TO IPLETION OF CAUSE
ED							I I ES	-		YES 2 (
Σ	DID TOBACCO USE CONTI	DIBLITE TO CALISE O	E DEATH Y	ES 🗍	NO F	1 UNCERTAI	N IS		'"	TES 2100
SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE			ONCERIAI				
2	EXAMINER?	HOSPITAL:		OTHE	R:					
ΙXS	1 YES 2 XNO	26e. DATE OF INJURY	28b. TI		28c, INJ		8 Other (Specify) 28d. DESCRIBE HOW	IN ILIDY OCCUR	REO	
РНУ	1 Natural 5 Pending	(Month, Day, Year)		IJURY M	WO	PRK7	Egg. DEGG!!!DE !!G!!			
ВУ	2 Accident Investigation	28s. PLACE OF INJURY	/ — At home farm	atreet for			28f. LOCATION (Street	and Number or	Rural Route	Number
G	3 Suicide 6 Could not be determined	building, atc. (Spec	city)	4.000, 100	10.71 0		City or Town, Stete			,
山	29e. CERTIFIER	100000000000000000000000000000000000000	entrace (Cons		- Luu			A Common of		
MPL	(Check only	CIAN: To the best of my know								I manage on minted
COM		R: On the beals of examination	ni and/or investigat	ion, in my i	оринюп, б					
BE	29b. SIGNATURE AND TITLE OF DEBINE	0	1			29c. LICENSE NU		29d. DATE S	IGNED (Mon	nth, Day, Year)
0	30 NAME AND ACCRESS OF PERSON WH	O COMPLETED ONLINE OF THE	1 77	7/7		107	540	- //	113	y 15

900

DHMH-16 Rev 1/89



	BALTIMORE, MARYLAND 21203-3146	ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Jours after death. Page 6 may be retained by the hospital or attending physic	
	BALT	s after death.	
4		non	
•		in 24	
	, Q	with	
	DIVISION OF VITAL RECORDS, P.O. BOX 13146,	executed	
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ing physician.	10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page: he fined within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	
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nospital	ached for	ce.
by me	be det	at on
retained	5 should	otified
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MILLIAN DE	omplete	event,
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aw requ	s been	23 sho
N: Ine	State D	Item .
HYSICIA	is certif	ted, or
OING PI	death v	s mark
ATTEN	RECTOR:	m 28 i
TAL OF	RAL DIF	: It ite
O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts are death, Page to may be retained by the mospital of at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur he fleet within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
P	0 9	MP

						95	34120
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)			White	2. DATE OF DEATH MONTH DAY	95	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 578-30-86-73 98. EACHLITY NAME (If not institution, give steel	5. SEX 1 M 2 DF Real and number)	YRS. MONTH	DER 1 YEAR OF UNDER 24 HRS. B DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day Jeer), 9/1	OUNTY OF DEATH	FRO INA
DIRECTOR	RESIDENCE OF DECEDENT	MAnor		ROOLD NORLOCATION	An	ine A	Rundel
	MARY AND HAND	e ARunde	GE	Burne	10g. C		I INSIDE CITY LIMITS? YES 2 NO COUNTRY?
FUNERAL	1514 BARRA	ck LAME		2106	/	18.	A
BY	1 Diever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 ☐ YES 2 I IF YES, GIVE WAR OR DATES	NO	IS. WAS DECENDENT OF HISPA If yes, specify Curen, Mexic 1 YES 2 WAYO Speci	ny:	Black, Wh	American Indian, hite, etc.
APLETED	15. DECEDENT'S EDUC (Specify only highest grade : Elementary/Segradary (0-12)	CATION 16a. Completed) College (1-4 or 5+)	Give kind of work do	ne during most of working d.)	166. KIND OF BUSINESS/	NDUSTRY	
BE COMPL	17. FATHER'S NAME (First, Middle, Linst) WILLIAM GLA	dden		Min	AME (First, Middle, Malden, Surname	"/	
2	Anice P.W.	Speen	15/4	ESPICITION and Number or Rural	Ane Gen	Burr	2106/md
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donellon 5 Other (Specify)	oval from State	CE OF DISPOSITION	(Name of competery, crematory or	1 1/24 BLOO	City or Town	ok md.
	21. SKINATINE OF FUNERAL SERVICE US	lams or	res	ARShall HOLESMAN	W. Jones	BAH	A PA
	23. PART I. Enter the diseases, or c ahock, or heart failure. I IMMEDIATE CAUSE (Finel	complications that caused the List only one cause or each i	death. Do not en			errest,	Approximete Interval Between Onset and Death
	disease or condition resulting in death)	DUE TO (OR AS A CON	SEQUENCE OF:	the 1	aneres		8- Month
NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CON	SEQUENCE OF):				
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON	SEQUENCE OF):				
CERT	reaulting in death) LAST	4					
EDICAL	PART ii. Other significant condition	a contributing to death but no	ot resulting in the	underlying cause given in	Part i. 24a. WAS AN AUTOPS PERFORMED?	AVA COI	RE AUTOPSY FINDINGS LILABLE PRIOR TO MPLETION OF CAUSE DEATH?
≥						Ŭ,	YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	्रा ।	26. PLACE OF DEATH (C			
PHYS	1 YES 2 DAG 27. MANNER OF DEATH 1 Tatural 5 Pending	1 Inpatient 2 ER/Outpatient 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Home 5 Residence 28c. INJURY AT WORK?	a Other (Specify) 28d. DESCRIBE HOW INJURY	DCCURED	
ED BY	2 Accident Investigation 3 Suicide a Could not be determined	28e. PLACE OF INJURY — As building, etc. (Specily)	t home, farm, street,	1 YES 2 NO	261. LOCATION (Street and Num City or Town, State)	ber or Rural Route	Number,
Ē	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowledge.	, death occurred at t	he time, date and place, and du	s to the cause(s) and menner as	atated.	
COMP	000)	R: On the basis of examination and	The second country	29c. LICENSE NU		OATE SIGNED (Mo	
8	(1) 1000 44	Actendo	X	D	2 1684	1) /	C. S.

HEGGWAY

GLBNBURNIN

29c. LICENSE NUMBER
D2 1684 29d. DATE SIGNED (Month, Day, Year) 11-14-95

296, SIGNATORE AND TITLE OF CERTIFIER

WELLY SELLY Actually Do Joh

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ALL CONTROL OF CONTROL 31. DATE FILED (Month, Day, Year)
NOV1 71995

17021061.

03 ... = = .

YEAR

9c. COUNTY OF DEATH

REG NO

November 17,1995

2. DATE OF DEATH MONTH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Florence

31. DATE FILED (Month, Day, Yeer) NOV1 71995

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4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR 1 M 2 V F 212-74-3685 95 June 11,1900 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 8648 Hoerner Avenue DIRECTOR Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10h COUNT 10e. STATE Maryland Baltimore County Baltimore permit. FUNERAL 10f. ZIP CODE burial-transit 8648 Hoerner Avenue 21234 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 Never Merried 2 Merried 1 TES 2 X NO Specify: B 3 X Widowed 4 Divorced as the ETED 15. OECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY use (Specify only high (Give kind of work done life. Do NOT use retired.) Elementery/Secondery (0-12) College (1-4 or 5 +) funeral director, page 5 should be detached for 8th Grade COMPL Homemaker Own Home once. t7. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Unknown Ħ Heck Mary Unknown notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Pau1 James Zinck 8648 Hoerner Avenue, Baltimore, MAryland-21234 pe 20e. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 1 Suriel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 11/20/95 Gardens of Faith Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 6415 Belair Road 21206 alphen John C. Miller, Inc. Baltimore, MAryland completely filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, abock, or heart failure. List only one cause on each line. 0 IMMEDIATE CAUSE (Final cremation. the within 24 LENDIE CARDIOVASCULAN disease or condition resulting in death) HERROSC other traumatic event, SEASE executed to burial. CERTIFICATION and Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING physician æ the attending physician Mental Hygiene prior certificate CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 10 death injury. PART II. Other algniticant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? the MEDICAL been signed by t any that 1 | YES 2 | 100 requires Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 3W 23 this certificate has with the State Dep 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item **EXAMINER?** 1 YES 2 NO OTHER: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Reeldence 8 Other (Specify) PHYSICIAN: 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28b. TIME DF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident OR ATTENDING 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 649 8 Could not be COMPLETED 200 4 Homicide Item 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated. FUNERAL (within 72 h = 2 🔲 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurad at the time, date end piece, end due to the ceuse(e) end manner ee steted. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 296, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CASSLANEGO 8813 WALTHAM WOODS-BATTIMONE-2123K -SEVEGIO

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Zinck

34721

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Maryland

10g. CITIZEN OF WHAT COUNTRY?

United States

Marley

Baltimore County

14. RACE — American Indien Black, White, etc.

White

Interval Between

Onset and Daath

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

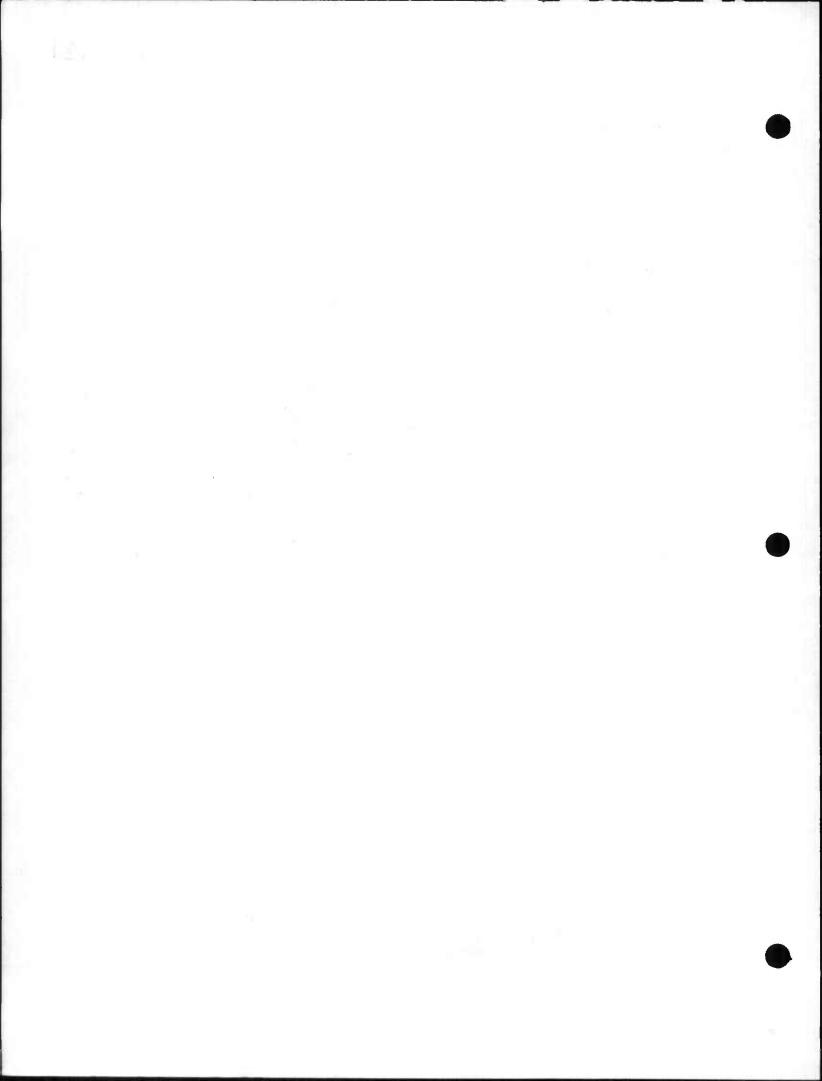
COMPLETION OF CAUSE

10d, INSIDE CITY

1 TES 2 NO

5:00 A.

DHMH-16 Rev 1/89



TO BE COMPLETED BY FUNERAL DIRECTOR

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	ay bi	page		pe l
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	Page	al dire		ner
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the P	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be deta		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at onc
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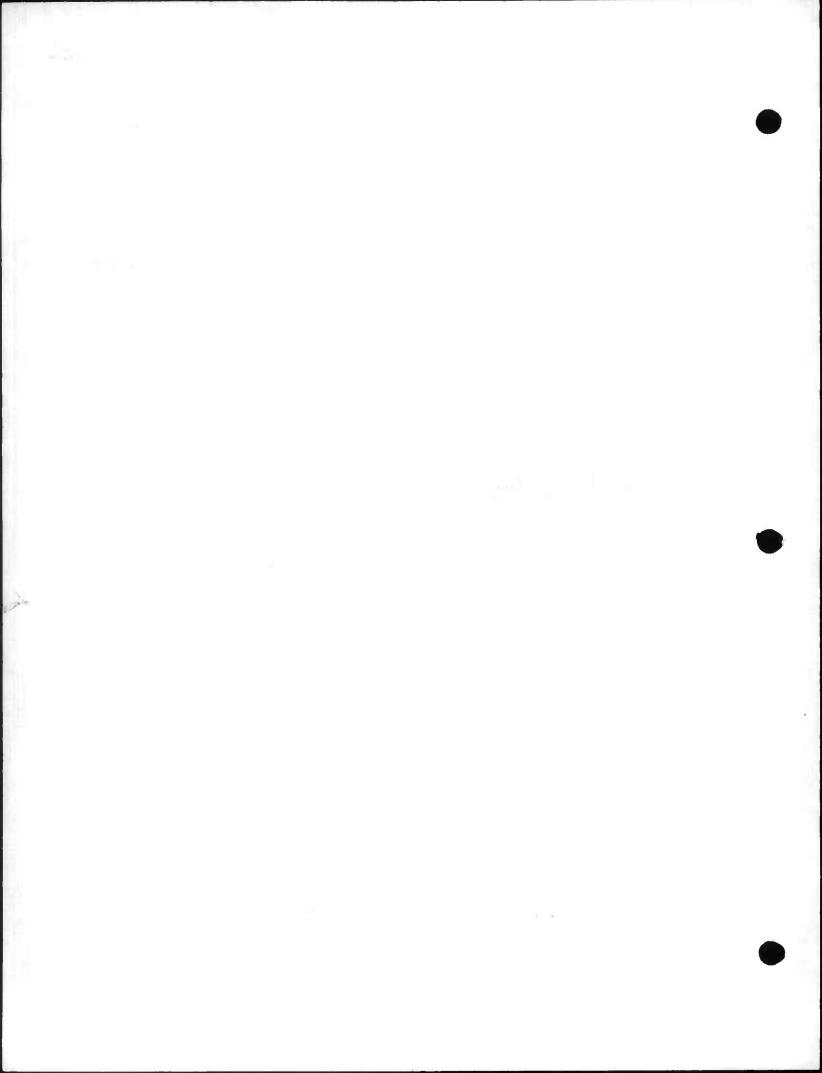
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR	OF MARYLAND /	DEPARTM ERTIFICA			MENTAL HYGI			
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	Н		3. TIME OF DEATH
ROSE MARIE	ZIPPLER				November	14,19	95	1:00 P. M
4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. les		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea			LACE (State or Foreign
213 14 3539 1□M:	² 🗓 F 73	YRS. MOR	ITHS DAYS	HOURS MIN.	03 02 2		Mary.	
9a. FACILITY NAME (If not institution, give street and nu	mber)			R LOCATION OF DE	EATH	9c. COUP	TY OF DE	
412 Imla Street			Baltim	ore	_	N/Z	A	
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c CITY TO	OWN OR LOCAT	ION				10d. INSIDE CITY
Md. N/A			timore				İ	LIMITS?
10e. STREET AND NUMBER			101	ZIP CODE		10a, CITI		AT COUNTRY?
412 Imla Street				21224			SA	
11. MARITAL STATUS 12. WAS I	DECEDENT EVER IN U.S. AR	MED	13. WAS DEC	ENDENT OF HISPAN	NIC ORIGIN? (Specify	Yes or No —	14. RACE	- American Indian,
IE AE	ES? 1 ☐ YES 2X N S, GIVE WAR OR DATES	10		cify Cuban, Maxica 2 NO Specifi	n, Puerto Rican, etc.)		White, etc.
3 Widowed 4 Divorced							Whit	e
15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(G	CEDENT'S USU	done during mo:	N st of working	16b. KIND OF	BUSINESS/IND	USTRY	
	(1-4 or 5+)	Do NOT use rel	,		Tai	lor		
Unknown 17. FATHER'S NAME (First, Middle, Last)		Callisti	C55					
Michael Napoli					ME (First, Middle, Ma hine Laz			
19a. INFORMANT'S NAME (Type/Print)	19	h. MAILING ADI	neess (Street a		Route Number, City or		Codel	
Thomas J. Zippler					more, Md			
20a. METHOD OF DISPOSITION		AND DATE OF D			-	LOCATION -		n. Stata
1 Dorietion 5 Other (Specify)	State cemetery, cre	metory or other p	olace)	4.4	-17-95			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	dens o	22, NAME AN		ciler & S			
1 P 19 19	alle							
23. PART I. Enter the diseases, or compliced	one that severed the de	eth De net			Ave. Bal			1 0
ehock, or heert fellure. Liet only			enter the mo	de of dying, auc	n em cerdiec or n	eepiratory em	eat,	Approximate Interval Between
IMMEDIATE CAUSE (Finel disease or condition	Hyperters	· C11	, di	1113-11-01	Dices	1- 8		Onset and Death
resulting in death) e	DUE TO (OR AS A CONSE		40000	1000000	n Vye			grais.
								1
Sequentially list conditione, If any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE OF):						
cause. Enter UNDERLYING CAUSE (Disease or Injury								
thet initieted events	DUE TO (OR AS A CONSE	OUENCE OF):						
resulting in death) LAST								
PART II. Other eignificent conditions contrib	uting to deeth but not i	resulting in th	ne underlying	cause given in	Part I. 24a. WA	S AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS
				5	PE	REPORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
			_		1 U YE	S 2 NO	- 1	OF DEATH? 1 ☐ YES 2 🛣 NO
DID TOBACCO USE CONTRIBUTE	TO CAUSE OF DEA	TH YES	ПИОГ	UNCERTAI	N IXI			I T LES 5 M MO
25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (OTTOERING	· pat			
EXAMINER? 1 YES 2 NO 1 Input	TAL: tlent 2 - ER/Outpetient 3	DOA 4	THER:	5 X Residence	6 Other (Specify)			
27. MANNER OF DEATH 26s.	DATE OF INJURY (Month, Day, Year)	26b. TIME OF	F 28c, INJ		26d, DESCRIBE H	OW INJURY OC	CURED	
1 Natural 5 Pending 2 Accident Investigation	(MORITI, Day, rear)	INJUNT		ES 2 NO				
3 Suicide 6 Could not be	PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, stree	t, tactory, office		261. LOCATION (St. City or Town, S	reet and Number	or Rural Ro	oute Number,
4 Homicide detarmined					ony or torn,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the	ne best of my knowledge, de	eath occurred at	t the time, data	and place, and due	to the cause(s) and	manner as stat	ed.	
one) 2 MEDICAL EXAMINER: On the I	basis of examination and/or	Investigation, in	ny opinion, d	eath occured at the	time, data and plac	e, and due to th	e cause(s)	and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER	29d. DAT	E SIGNED	(Month, Day, Year)
Kobert Filests	ins.			Dan	xhv	•	11/15	79/
30. NAME AND ADDRESS OF PERSON WHO COMPLE	TED CAUSE OF DEATH (ITE	M 27) (Type, Prir	71)	(0)	107		1	
350 DAUB 17	0 -	1.0	1000		1 - 11	and a 86 I	TY.	
3508 BANK ST	BALTO, M	rel,	2120	Ly Rox	ert Libe	rto M.	D.	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2.7 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTABLY If fam 28 is marked, or item 23 shows any injury or other transmitted event, the medical eventual event.
--

permit. Pages 1, 2, 3 should

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) Felice	Agnolutt	0			2. DATE OF DEATH MONTH NOVEMber		3. TIME OF DEATH 10:15PM M
	4. SOCIAL SECURITY NUMBER 092-05-5675-A	<u>MX</u> м 2 □ F		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) November	a, Bretti	IPLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give s Bradford Oaks RESIDENCE OF DECEDENT		9		inton	ATH	9c. COUNTY OF E	George's
DIRECTOR	10a. STATE 10b. COUNT	e George's	10c. CITY, 1	Brandy				10d. INSIDE CITY LIMITS? 1 YES 2 ANO
FUNERAL	100. STREET AND NUMBER 11902 Lusby Lane				ZIP CODE	613	10g. CITIZEN OF V	VHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 100		cify Cuban, Maxica	IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	Blac Spec	E — American Indian, k, White, atc. thy: Casian
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 6th		Give kind of working. Do NOT use of Tile Sett	k done during mo etired.)	DN st of working		SINESS/INDUSTRY	Marble &Tile
BE CON	17. FATHER'S NAME (First, Middle, Last)	Benedetto	Agnolutto)	18. MOTHER'S NAI	ME (First, Middle, Malden	Surname)	
10	19a. INFORMANT'S NAME (Type/Print) Carolina D. Allin	ng				noute Number, City or Town		
	29a. METHOD OF DISPOSITION 1 X Burlal 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIE	oval from State	PLACE AND DATE OF	Cemete	ery Novl	,1995 Sui		ryland
	bt 5. 5	Ditt		Old A	Lexandria	a Ferry Ro	ad, Clint	e,Inc 6633 con,Md 20735
CERTIFICATION	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO JOR AS A	CONSEQUENCE OF:	lender the mo	a)		Approximate Interval Batween Onset and Death
MEDICAL	PART II. Other significant condition DID TOBACCO USE CONT	Cheine	ry,	Egge	Cause given in	PERFO	IMED?	WERE AUTOPSY FINDINGS ANALASIE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 700	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outp	26. PLACE OF DEATH	(Check only one)	s S 🗍 Residence			
BY PH	27. MANNER OF DEATH Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	10	ES 2 NO	and DESCRIBE HOW	()=01120120100	
	3 Suicide 6 Gould not be determined	28e. PLACE OF BUILDS building, els-150ec	***	1000 Page 8, 1000		28f. LOCATION (Street City or Them, State)	person meneroestations L	houte Number
COMPLETED	(Check only 1 CENTIFYING PHYS)	CIAN: To the best of my knowl Ft: On the basis of examination			with occured at the	time, date and place, ar	d due to the cause(s	
TO BE	30. NAME AND ADDRESS OF PERSON WH	2 /11/	ATH (ITEM 27) (Type Pr	int)	29st LICENSE NUM	259	▶6 70	Month, Day Years
	Rene Grace M.	D. 9131 Pis	scataway I		inton, Ma	aryland 20	735	
	31. DATE FILED (MOODY, Oby, Year) 7 199	5 Julia d'ave	dear Randall					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020	in 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should to the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
C	ERTIFICATE	OF DEAT	ГН		REG. NO.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH CERTIFICATE OF DEAT		TAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) LOTTA LAVENE ATCHISON		tober 2	7, 19		TIME OF DEATH 8:10 P M
	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	MIN. OC	ATE OF BIRTH forth, Day, Year) t. 30,19	904	Washi	ngton, D.C.
TOR	98. FACILITY NAME (If not institution, give street and number) CARROLL MANOR NURSING HOME RESIDENCE OF DECEDENT 99. CITY, TOWN OR LOCATION Hyattsville				CE GE	orges
DIRECTOR	10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Hyattsville				1 2	d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	106. STREET AND NUMBER 4922 LaSalle Road 20782			USA	EN OF WHA	T COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 4 Divorced 12. Was DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 1 Yes, apecify Cubar 1 YES 2 NO	en, Maxican, Pus		or No-	Black, W	American Indian, Inita, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of workin life. Do NOT use refired.) Home maker	ing	16b. KIND OF BUS	SINESS/INDU	JSTRY	
BE COM	17. FATHER'S NAME (First, Middle, Last) 18. MOTH	tta Ros	irst, Middle, Maiden	Surname)		
TO B	19a. INFORMANT'S NAME (Type/Print) William P. Atchison 19b. MAILING AGORESS (Street and Number 824 Villa Ridge Ro		lls Chur	ch, V	/A 220	
	20a_METHOD OF DISPOSITION 1	10,	/31 Sui	tland		State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. P. Marshall S 4308 Suitl					0746
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dyl shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) s. JPS/S	ying, auch as	cardiac or reap	ratory arm	eat,	Approximate interval Between Onset and Death
N	DUE TO (OR AS A CONSEQUENCE OF): OVERWHELMING INFECTION Sequentially list conditions,					thurs
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	INFERE	w/			YEARS
PHYSICIAN: MEDICAL CE	PART II. Other significant conditions contributing to death but not resulting in the underlying cause of Service Demersia Acz Herniers / MULTIPLE DE CUBITI		PERFOR	RMED?	CI	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 70
SIAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	CERTAIN [1			
HYSIC	To perfer to the first to the f		Other (Specify) . DESCRIBE HOW	NJURY OCC	CURED	
ВУ	1 Natural 5 Pending Investigation 2 Accident Suicide 8 Could not be detarmined September 1 Natural September 2 Natural September 2 Natural September 3 Natural September 2 Natural September 3 Natural Septemb		LOCATION (Street City or Town, State)	and Number	or Rural Rou	te Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occur					nd manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CRITIFIER LAUND 1 CULLAN W 50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4333 OLD BRANCH MENUE MARLOW HEICE	CENSE NUMBER	7		30 / 7	fonth, Day, Year)
	4333 OLD BRANCH AVENUE WALLOW HELD.	HD, Le	ACYLAND			
	31. DATE FILED (MONID Day, Year) 32. RIGISTRAD'S SIGNATURE Julia d'Audion Randell					

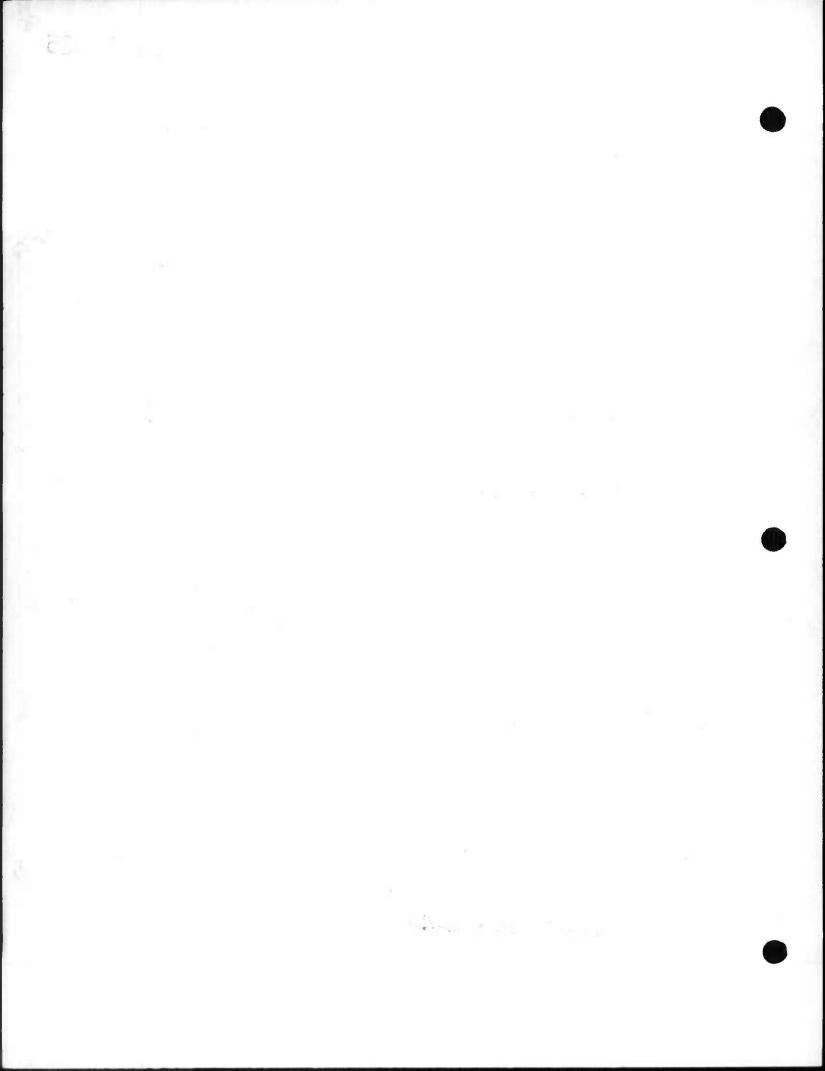
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State flent of Health and Mental Hydione notes to have a compact. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIFI	CATE OF DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF OEATH				
	JOSEPH ALOYSIUS				October 2		1:25 P M				
		1 X M 2 F	(In yrs. lest birthday) 72 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cou	ATHPLACE (State or Foreign untry) Ashington, DC				
	9a. FACILITY NAME (If not institution, give street	net and number)		9b. CITY, TOWN OR LOCATION OF D		9c. COUNTY OF					
DIRECTOR	8314 Oglethorpe St			New Carrollton			George's				
🖺	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION								
		George's	New	Carrollton			10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
FUNERAL	100. STREET AND NUMBER 8314 Oglethorpe St	treet		101. ZIP CODE 20784		U.S.A.	F WHAT COUNTRY?				
5		12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No 14. RA	ACE — American Indian.				
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 V YES	2 NO PATES	If yes, specify Cuban, Mexic 1 YES 2 NO Speci	en, Puerto Rican, etc.)	Ble	eck, White, etc. White				
TED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	(Give kind of w	USUAL OCCUPATION ork done during most of working	16b. KINO OF BUS	SINESS/INDUSTRY					
once.	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Physicis	,	Private						
ON ON	17. FATHER'S NAME (First, Middle, Last)										
10 m	Joseph Henry Aukward Mary Evelyn Quinn										
TO B	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street and Number or Rural							
	Eileen F. Aukward		8314 0	glethorpe Stree	t, New Car	rollton,	, MD 20784				
medical examiner must be	20s. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	el from State		FDISPOSITION (Name of ler place) aven Cemetery 10		CATION — City or					
9	21. SIGNATURE OF FUNERAL SERVICE LICEN	NSEE	or ne	22. NAME AND ADDRESS OF FA	CILITY	ver spr	ing, maryland				
ехаш	1 M B C	7 4 4 4 4 5		22. NAME ANO ADDRESS OF F Francis Gasch 4739 Baltimor							
E	23. PART i. Enter the diseases, or cor	mplications that cause	d the death. Do no	ot enter the mode of dving, suc	h as cardiac or respi	ratory arrest	Approximata				
E	shock, or heart fallure. List	st only one cause on e	each line.		1000		interval Between Onset and Death				
th.	disease or condition resulting in death)		11	pate (A	ua.		Bollen				
went	resulting in death)	DUE TO (OR AS	удонявация об	parer for	700		July 1				
any injury, or other traumatic event, the DICAL CERTIFICATION	Sequentially list conditions, The Delastic Conditions 15 Maris										
ATI	If any, leading to immediate cause, Enter UNDERLYING										
F S	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	comsential Cont	ycarcinona	01 000	21	76 mount				
ry, or other traumatic	resulting in death) LAST	C									
Ç 2	DADT is Other elevisional conditions										
vs any Inju	PART ii. Other algnificant conditions	contributing to death b	out not reaulting in	the underlying cause given in	Part I. 24s. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
E 2					1 _ YES 2	NO	OF DEATH?				
og S	DID TODACCO LICE CONTROL	DUTE TO CALLEE O					1 - YES 2 NO				
23 AN	DID TOBACCO USE CONTRII	BUIE TO CAUSE C			N D						
SICIAN:	EXAMINER?	HOSPITAL:		OTHER:							
	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME	4 ☐ Nursing Home 5 Mesidence OF 28c. INJURY AT	8 Other (Specify) 28d. DESCRIBE HOW II	N HIEW OCCUPED					
marked, BY PH	1 Pending Investigation	(Month, Day, Year)	INJU	M 1 YES 2 NO	200. DESCRIBE HOW II	NJUHY OCCURED					
<u>∞</u> 0	3 Suicide 8 Could not be	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm, st	reet, factory, office	281. LOCATION (Street a	and Number or Rura	I Route Number,				
m 28 ETE	4 Homicide determined	January Vice (open	y)		City or Town, State)						
월	290. CERTIFIER (Check only	AN: To the best of my know	ledge, death occurred	at the time, data and place, and dua	to the cause(a) and man	mer as stated.					
MPORTANT: IF	one) 2 MEDICAL EXAMINER:	On the baels of examination	and/or investigation	, in my opinion, death occured at the	time, data and place, an	d dua to the cause	e(a) and manner as stated.				
E C	296. SIGNATURE AND TITLE OF CERTIFIER	11/11	1/2	29cMCENSE NUI	MBER,	29d. DATE SIGNE	ED (Month, Day, Year)				
IMPC O B	pur	64/10	elan	MI 107	14/9	> Set	30 1995				
F	Thomas Malanay M	/				20724	7				
	Thomas Maloney, M. 31. DATE FILED (MOUTE DOLL 1995)	327545TP.016.884	Avenue	e, Hyattsville,	Maryland 2	20784-16	007				
	UC 1 3 0 1995	Jan .									



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DIVISION OF VITAL RECORDS, P.O. BC	2000
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos to THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	res that the death certif	igned by the attending I	ealth and Mental Hygien	rs any injury, or oth
TO THE FUNERAL DRECTOR: After this be filed within 72 hours after death wit IMPORTANT: If Item 28 is marke	SICIAN: The law requi	certificate has been s	th the State Dept. of H	d, or item 23 show
TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: I	OR ATTENDING PHY	L DIRECTOR: After this	2 hours after death wit	f item 28 is marke
1 1	7	S	ithin 7	ANT: I
~	TO THE HOSPITAL	TO THE FUNE	be filed w	IMPORT

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR Certif				MENTAL	HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	MARIE		165			2. DATE MONTH	OF DEATH		YEAR 9.5	3. TIME OF DEATH 7:04 P M
1		SEX 6. AGE (In y	5 yrs.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Month)	о г виятн , _{Day, Убаг)} 6,19	40	6. BIRTH Countr UNI	ON TOWN,
TOR	98. FACILITY NAME (If not institution, give street PRINCE GEORGE 1.5 RESIDENCE OF DECEMENT					VERLY	ATH			CE (eorge's
DIRECTOR	10s. STATE 10b. COUNTY	E GEORGE'S		y, town o		ON					10d. INSIDE CITY LIMITS? Y YES 2 NO
FUNERAL	100. STREET AND NUMBER 2910 BRIGHTS	EAT ROAD #	101			ZIP CODE 20706			10g. CITI		VHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U. FORCES? 1 YES: IF YES, GIVE WAR OR OATE	2XX10			ENDENT OF HISPAN city Cuban, Maxica XIXNO Specify	n, Puarto R		or No-		E — American Indian, k, White, atc.
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) 12th	ION 16 npleted) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done se retired.)	during mos	at of working		.G. C			GOVERNMENT
BE CON	17. FATHER'S NAME (First, Middle, Last) ERNEST CHAPP	ELL				18. MOTHER'S NA	111				
TO B	19e. INFORMANT'S NAME (Type/Print) ANTHONY ALSTO 20a, METHOD OF DISPOSITION 1 A Burlai 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS	of I from Stata 20b. PL cemete	2910	BR I	EGHT SITION (Nai DRIA NAME AN	L PARK	D. #	101 I	LANH cation — NDOV	AM, City or To	rwn, Stata
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		Therese on Nonsequence of Nonsequenc	Cerol						eet,	Approximate Interval Between Onset and Death Geans Geans Geans
PHYSICIAN: MEDICAL C	PART II. Other eignificent conditions of						_	24a. WAS AN PERFOR	RMED?	246	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN:	DID TOBACCO USE CONTRIE		PLACE OF DEA	OTHE	R:	- N - 127/2 - 277					
BY PHYS	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIR		28c, INJI WO 1 Y	RK?		CRIBE HOW	NJURY OC	CURED	
ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, atc. (Specify)	Al home, farm,	street, fac	tory, office			ATION (Street or Town, State)		or Rural I	Route Number,
COMPLET	Crieck Orny	N: To the bast of my knowled On the basic of axamination a									a) end manner as stated.
TO BE C	29h. BIGNATURE AND TITLE OF CERTIFIER SCROOL MD 30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED OFFICE				D 259	MBER 25				30,1995

J. BERGER MD # 205, 7720 WISCONSIN AVE, BeThesda, Md

1. OATE FILEO (Month, Doy, Mar)

1. OATE FILEO (Month, Doy, Mar)

1. OATE FILEO (Month, Doy, Mar)

1. OATE FILEO (Month, Doy, Mar)

31. OATE FILEO (Month, Day, Year)
NOV 02 1995

FOR

	REGISTRAR CERTIFICA	ATE OF DEATH	REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
	CLARA BANGSUND ABRAHAM		OCT. 28,1995	5 3:30 PM M
	E42 26 7707		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	X 101	CITY, TOWN OR LOCATION OF DE	MAR.3,1894	MINNESOTA
R		EASTON	ATH 9c. COU	TALBOT
DIRECTOR	RESIDENCE OF DECEDENT			
IRE	10c. STATE 10c. COUNTY 10c. CITY, TO	WN OR LOCATION		10d. INSIDE CITY LIMITS?
		EASTON		XX YES 2 NO
FUNERAL	3 NORTH THOROGOOD LANE	10f. ZIP CODE 21601		USA
F.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES GIVE WARD OR DATES A	13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Maxican	IC ORIGIN? (Specify Yea or No-	14. RACE — American Indian, Black, White, atc.
ΒY	3 Wildowed 4 □ Divorced IF YES, GIVE WAR OR DATES	1 YES 2 NO Specify	:	Specify:
	15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUA		18b. KIND OF BUSINESS/IND	WHITE
COMPLETED	(Specify only highest grade completed) (Give kind of work of life. Do NOT use retired in the control of life. Do NOT use retired in the control of life. Do NOT use retired in the control of life. Do NOT use retired in the control of life. Do NOT use retired in the control of life.	done during most of working ired.)	100000000000000000000000000000000000000	
MPI	12 HOUSEWII	FE	OWN HON	ME .
	17. FATHER'S NAME (First, Middle, Last)		ME (First, Middle, Maiden Surname)	
8	OTTO K. BANGSUND 19a, INFORMANT'S NAME (Type/Print) 19a MAII ING ADDI		LIE BERRE	
2	Too male to a second		Noute Number, City or Town, State, Zip	ron, MD 21601
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DIS	SPOSITION /Name of		City or Town, State
	1 Burlet 2 XCremation 3 Removal from Stata 4 Donation 5 Other (Specify) SALJSBURY	CREMATORY		BURY, MD
ļ	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACTOR	RAL HOME, P.A	
	YOHA R MERCERON CEST		ISON ST., EA	
	23. PART I. Enter the diseases, or complications that caused the death. Do not el ahock, or heart failure. List only one cause on each line.	nter the mode of dying, such	as cardiec or respiratory arr	rest, Approximate
	IMMEDIATE CAUSE (Final disease or condition			Interval Between Onset and Death
	resulting in deeth) e. Due to (or as a consequence or):			3 years
_	DUE TO (OH AS A CONSEQUENCE OF):			
CERTIFICATION	Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):			
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury			
E	thet initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST			
E I	d			
DICAL	PART II. Other significent conditions contributing to death but not resulting in the	e underlying ceuse given in t	Part I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DIC			1 - YES 2 0-NO	COMPLETION OF CAUSE OF DEATH?
ME			_	1 TYES 2 NO
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (CA			
SIC	EXAMINER? HOSPITAL: OTI	HER:		
PHYSICIAN:	27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF	28c. INJURY AT	B Other (Specify) 28d. DESCRIBE HOW INJURY OCC	CURED
ВУР	1 Netural 5 Pending (Month, Day, Year) INJURY 2 Accident Investigation	M 1 YES 2 NO		
60	3 Suicide 8 Could not be 28a. PLACE OF INJURY — At home, farm, street, building, etc. (Specify)	, factory, office	281. LOCATION (Street and Number City or Town, State)	or Rural Route Number,
E				
AP	29a. CERTIFIER (Check only one)			
COMPLET	2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in i	my opinion, death occured at the t	lime, data end place, and dua to th	a cause(a) and manner ea stated.
8	296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUM	6100	E SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	DAI	707	0-00-95
	LAWRENCE D. BOHAN, M.D., 606 DUTC		EASTON MD	21601
		THAT D HAND	, EASTON, MD	, 21001
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE OCT 3 1 1995 Julia Davulca-Ravial			

1.5

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death within 25 attending physician.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

				_				DEATH		EG. NO.			
	1. DECEDENT'S NAME (First	, Middle, Last)							2. DATE OF U				3. TIME OF DEATH
1	WILLIAM	Μ.		ABB(TTC				NOVEMB	ER 6		95	12:30 A M
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In y	rrs. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7 DATE OF B	UDTH			1PLACE (State or Foreign
	217-10-5992		1 🔀 M 2 🗆 F	84	YRS.	MONTHS	DAYS	HOURS MIN.	Sep 14	(Year) T Q	11	Count	
	9a. FACILITY NAME (If not in	stitution, aive =				9h CITY	TOWN	B LOCATION OF T		1, 13		NEW 4-	
œ				AT OF	TOTAL S		BE. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND AT.J.E.GANY						
6		MEMORIAL HOSPITAL & MEDICAL CENTER (AND			ALL	EGAN	Y
	10a. STATE	10b. COUNTY	Y		10c. CIT	Y, TOWN O	R LOCAT	ION					10d, INSIDE CITY
DIRECTOR	MD	Alle	ganv			mberl							LIMITS?
	10e. STREET AND NUMBER		3 1		1 001			710 00DT		1			1X YES 2 NO
FUNERAL	1430 Magr	olia	Court				1	ZIP CODE			USZ		WHAT COUNTRY?
岁		OTTA						1502				.7	
2	11. MARITAL STATUS 1 Never Married 2	Mambad	12. WAS DECEDEN FORCES? 1	T EYER IN U.	S, ARMED	13. W	AS DECI	ENDENT OF HISPAI	NIC ORIGIN? (S	pecify Yan	or No-	14. RACI	E — American Indian, k, Whita, atc.
BY	3 Widowed 4 Divo		IF YES, GIYE W					2 NO Specif		, areal		Spec	My:
			l									1	white
ED	15. DEC (Specify only	EDENT'S EDU	CATION completed)	16	Give kind of	work done di	CUPATIO	N at of working	16b. KIN	D OF BUSI	NESS/INC	USTRY	
	Elementary/Secondary (0	-12)	College (1-4 or 5 +	+)	Iffe. Do NOT us	e retired.)							
	12				Spinni	ng De	epar	tment	Te	extil	.e		
COMPL	17. FATHER'S NAME (First, M	iddle, Last)						18. MOTHER'S NA	ME (First, Middle	, Maiden Ş	umame)		
BE	Charles	L. Abb	oott				- 1	Eliza	beth (Guthi	cie)		
	19a. INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADDRESS	(Street as			le Number, City or Town, State, Zip Code)			
2	Betty Jane		r					Ridgeley			_	July	
	29p. METHOD OF DISPOSIT			201 61						2675.	_		
	14 Burial 2 - Crematio	n 3 🗆 Rame	oval from State		ACE AND DATE OF OR OF OR OF OR OF OR				0ATE	Cum		-	
	4 Donation 8 Other 21. SIGNATURE OF FUNERA	. , ,	PEUDEF	_ [H1]	LICTEST				11/08	cum	perl	and,	MD 21502
- 1	21. SIGNATURE OF FUNERA	SERVICE LIC	ENSEE		1,	22. N	AME AN	elli Fur	CHITY	omo			
	Jana	21	R/Mais	011	1 -			rland, M					
	23. PART . Enter the di	seases, or o	omplications the	t viceused th	a death. Do r						tory arr	not .	Approximate
	anock, or no	sart failura.	Liat only one cau	aa on each	ine.			a or aying, oac	ii as caraiso	or roupire	noty and	out,	Interval Batween
- 1	iMMEDIATE CAUSE (Fin disease or condition	al	1.1										Onset and Daath
1	resulting in death)	→ ,	.Urose		5								Idays
			OUE TO	(OH AS A CO	INSEQUENCE OF	7:							
ξ	Sequentially list conditi	000	b										
<u> </u>	if any, leading to immed	diate	OUE TO	(OR AS A CO	INSEQUENCE OF	F):							
HILICALION	cause. Enter UNDERLYi CAUSE (Disease or Inju		C										
	that initiated events		DUE TO	(OR AS A CO	INSEQUENCE OF	F):							
Ĕ	reaulting in death) LAS		d										
5	DART II ON												
4	PART ii. Other algnifica	nt condition	e contributing to	deeth but i	not resulting i	n the und	lerlying	cause given in	Part I. 24a	WAS AN A		24b	WERE AUTOPSY FINOINGS
ااد	Arusta t) -	1 1							PERFORM			AMILABLE PRICE TO
5 11	7	Rena	1 Fails	LIP						PERFORM			AMILABLE PRIOR TO COMPLETION OF CAUSE
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	11 OD ATTENDIAL DUVELCIAM: The law consists the death confessed he consisted with

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Omended # 16 h, 11/3/95, MdS., Cellegony Co.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEA

STATE	0F	MARYLAN	ID /	DEPA	RTMENT	0F	HEALTH	AND	MENTAL	HYG	IENI
			CI	ERTIF	ICATE	O	F DEAT	TH		REG	NO

_	NEGIGI FAN		CI	SHILL	CATE	OF DE	EALIT		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, La	st)						2. DATE	OF DEATH		YEAR	3. TIME OF DEATH	
- 4	GENEVIEVE	M	ATT	LBURTIS									
	4. SOCIAL SECURITY NUMBER	5. SEX	. ACE (1- 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1			_		Nove		, 19		6:30 A. "	
	4. SOURE SECONT I NOMBEN		6. AGE (In yrs. les	st birthday)	MONTHS D	AYS HOL	JNDER 24 HRS.	(Month Day Year) Country)				IPLACE (State or Foreign	
	213-22-4197	1 🗆 M 2 📉 F	82	YRS.		1100	JANU MINI.	May	23,1	913	MA	ŘYLAND	
	9e. FACILITY NAME (If not institution, gir	re atreet and number)			9b. CITY, TO	OWN OR LO	CATION OF DI			_	NTV OF D	EATH	
r											9c. COUNTY OF DEATH		
DIRECTOR	Memorial Hospit	al & Medi	<u>cal Cent</u>	er	Cumb	er1a	nd			Allegany			
<u>ا ۱</u>	10e, STATE 10b, COU	NTV		1 40 000									
Ĭ					, TOWN OR							10d. INSIDE CITY LIMITS?	
- 1	MARYLAND A	LLEGANY		C	JMBER	LANL)					1 X YES 2 NO	
7	10e. STREET AND NUMBER					10f. ZIP	CODE			10a, CITI	IZEN OF V	WHAT COUNTRY?	
ř	18 N. LEE STR	FFT				21	1502			1	J.S.	Δ	
FUNERAL	11. MARITAL STATUS												
2	1 Never Merried 2 Merried	FORCES?	IT EVER IN U.S. AR	IMED NO	13. WA	B DECENDE	NT OF HISPAN Cuben, Mexica	NIC ORIOIN	(Specify Yes	or No-	14. RACE	— American Indian, t, White, etc.	
2	3 Widowed 4 X Divorced	IF YES, OIVE Y					NO Specifi		wait, etc.)	- 1			
	3 Widowed 4 A Divorced									ŀ		WHITE	
	15. DECEDENT'S E (Specify only highest gr	DUCATION			USUAL OCCU			16b.	KIND OF BUS	INESS/IND	USTRY		
EIED	Elementary/Secondary (0-12)	College (1-4 or 5	16a	ive kind of w . Do NOT us:	ork done duri e retired.)	ng most of w	working		SPINN	ING	DEP	ARTMENT	
7	8	College (1-4 or 3	" FAC	CTORY	WOR	KFR			CELAN		COR	PORATION	
COMPL				71011					2		001	11 011/11 1011	
3	17. FATHER'S NAME (First, Middle, Last)						MOTHER'S NA			Surname)			
	THOMAS HUGHES					8	BESSI	E HA	RDING				
	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILINO	ADDRESS (S	treet and Nu	imber or Rural I	Poute Numb	r Clty or Town	State 7/o	Codel		
2	DENNIS McGANN		F	COLLE	- 2	ROX	106 -	- KF	VSFR	WV		726	
- 1							100	- 1					
	20e. METHOD OF DISPOSITION 1	emoval from State	20b. PLACE / cemetery, cre			N (Name of		DATE	20c. LO	CATION	City or To	wn, State	
	4 Donation 5 (A Other (Specify)	ntombmer	It REST	IAWN	MEM	. GA	RDENS	11/3/9	5 L1	AVAL	E, 1	MD	
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22 NAI	ME AND AD	DDECC OF EA	CILITY					
- 1	Dalla I la	4 1	./)		GE	ORGE	- UPCH	IÑĠĊĤ	FUNI	RAL	HO	ME. P.A. D 21502	
	(yeara y)	Texher										D 21502	
	23. PART I. Enter the diseases, p	r complications the	t caused the de	ath. Do n	ot enter the	mode of	f dylng, suci	h aa cardi	ec or reaple	ratory arr	eat,	Approximate	
- 1	anock, or naert failui	e. List only one cau	ise on each line	١.							-1.12	Interval Between	
П	IMMEDIATE CAUSE (Finel disease or condition	DMEIMO	ATT A									Onset and Death	
	resulting in death)	PNEUMO!	NIA								5 days		
ı		DUE TO	(OR AS A CONSEC	DUENCE OF):								
. II		- SEPSIS										5 days	
2	Sequentially flat conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE OF	OF):								
₹	cause. Enter UNDERLYING	. URINAR	V TDACT	TNEEC							5 days		
- 1	CAUSE (Disease Dr Injury		(OR AS A CONSEC							Juays			
	that initiated events resulting in death) LAST	502.10	(ON AS A CONSEC	DENCE OF	/F):					i l			
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?	PART II. Other significant condit	one contribution to	double but and a				COLUMN TO A STATE OF	I					
į II	Trace ii. Other significant condit	one contributing to	deeth out not r	esulting if	n the unde	riying ceu	ise given in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
₹	HIGH BLOOD PRE	SSURE							I YES 1			COMPLETION OF CAUSE	
							,	_				OF DEATH?	
	DID TOBACCO USE CON	ITDIRLITE TO CA	HISE OF DEA	TU VE	C D NIC	. I	NICEDTAIN					1 YES 2 NO	
	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CA					INCEKIAII	7 📙					
5 1	EXAMINER?	HOSPITAL:	26. PLAC		OTHER:	one)							
2	1 TYES 2 NO	10 Inpetient 2	ER/Outpetient 3			Home 5	Residence	8 🗆 Other	(Specify)				
	27. MANNER OF DEATH	28e. DATE OF	INJURY	26b. TIME		. INJURY A	AT	28d. DE\$0	RIBE HOW IN	JURY OCC	URED		
: 1	1 Natural 5 Pending	(Month, D	ey, rear)	INJU		WORK?	2 NO						
	2 Accident Investigatio	28e PLACE O	F INJURY — At ho	me form et				204 1 2 2 2					
	3 Suicide 6 Could not to	building.	etc. (Specify)	······································	reet, ractory,	Office		City o	TION (Street as Town, State)	nd Number	or Hural H	loute Number,	
i	29e. CERTIFIER 1 CERTIFYING PH	SICIAN: To the best of	my knowledge, an	eth occurred	d at the time	date and n	place, and due	to the care	e(e) and man	ner ee eter	ad		
												end manner ee stated.	
3 1			7	veengenon	, at my opini	on, usern o	occurred at the	time, date (nd piece, end	due to the	e Ceuse(e)	end manner ee stated.	
	296. SIGNATURE AND TITLE OF CENTS	HEM (1			29c.	LICENSE NUN	IBER	1	29d. DATE	E SIGNED	(Month, Day, Year)	
. 1	111	1010				n	36766	;	1	> /	Vojin	hy 1, 1995	
: #	30. NAME AND ADDRESS OF PERSON	VHO COMPLETED CALL	E OF DEATH (ITES	# 27) /hm= :	Print)	1 1)	20700	,				, , ,	
					inanj				_				
	Dr. Vik Poonai.	955 Frede	rick St.	Cı	ımber]	and,	MD	2	L502-				
	31. DATE FILED (Month, Day, Year)	33 REGISTRA	H'S SIGNATURE	0 00									
- 11	NOV 03 199	5 Huma do	wellow-Mari	dall									
	0 100												

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within within the float float of page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MADVI AND / DEDADTMENT OF HEALTH AND MENTAL HYDREN

1 - STATE REGISTRAR				CENTIL	ICATE (ノト・レヒ	ATH		REG. NO			
1. DECEDENT'S NAME (First,	Middle, Last)	_						2. DATE C	F DEATH			3. TIME OF DEATH
EDNA ROMA	INE B	AUERLIE	N					NOV.	5, 1	995	YEAR	8:26 Pm
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs	. last birthday)	IF UNDER 1 YE	AR IF U	DER 24 HRS.	7. DATE O	F BIRTH		s. BIRTH	IPLACE (State or Foreign
213-16-1909		1 🗆 M 2 🖫 F	-	75 YRS.	MONTHS DA	YS HOU	IS MIN.		Day, Year) 18, 1	920	Mar	vland
9e. FACILITY NAME (If not in:	stitution, give st	reet and number)			9b. CITY, TO	WN OR LOC	ATION OF D		10/ 1		UNTY OF D	
Carroll Cour	nty Ger	neral Hos	pital		West	tmins	ter			C	arrol	.1
RESIDENCE OF DEC	EDENT											
					Y, TOWN OR LO							10d. INSIDE CITY LIMITS?
Maryland 100. STREET AND NUMBER	Cai	roll		We	estmi				-			1 Ty YES 2 NO
14 Ward Av	zenije					101, ZIP 0						ed States
11. MARITAL STATUS	Venue	12. WAS DECEDEN			13. WAS		157	NIC ORIGIN?	(Specify Ver			
1 Never Merried 2		FORCES? 1 IF YES, GIVE W		∑ MO	If yes	s, specify C		en, Puerto Ri		0. 110		— Americen Indian, c, White, etc.
¥∑ Widowed 4 □ Divo	rced				'-	120 1767	оросі	,			Speci	ite
	EDENT'S EDUC highest grade		180	DECEDENT'S	USUAL OCCUI	PATION a most of w	orkina	16b.	KIND OF BU	SINESS/IN	DUSTRY	
Elementary/Secondary (0	-t2)	College (1-4 or 5 +)	life. Do NOT us	se retired.)				9151	_		
10				Laboi	rer						turin	ng
17. FATHER'S NAME (First, Mi								AME (First, Mi				
Elmer Jacob								Cathe				
Wayne A. M					ADDRESS (Str							
20e, METHOD OF DISPOSITE					rancis		t Ke	y High				n, MD 21787
1 Buriel 2 Cremetio	n 3 🗆 Ramo	oval from State	cemetery MO3.0	Cremetory or of	ther place) anch Co	N (Name or amata	277	1			City or To	, Maryland
21. SIGNATURE OF FUNERAL		ENSEE	ricac	XOW DIC			RESS OF F	11/8	Me	5 OIHL	nocer	, Haryrana
Laura	-1 -1)	Land	4	N.)My	ers F	unera	1 Hom	9			
Succe	10107	BULL	KU	They	91	Will	is St	reet.	Wes	tmin	ster	MD 21157
23. PART i. Entar the di- ahock, or ha	seases, or c aart failure. I	omplications that lat only ona dau	csuper the	ina.	not anter the	moda of	dying, au-	ch aa cardi	ac or reap	ratory si	rrest,	Approximata intervel Batween
iMMEDIATE CAUSE (Fin disease or condition	ai	1/157	mo i	11.00	1, 5	5,12	0,1	117	n			Onset and Death
resulting in death)	→ ,	VD	7/101	naa		001	Cla	ago	^			I ma g
•		ODE TO	OH AS A CON	ISEQUENCE OF	n F	MARC	7 6	HSE.	ME			doth
Sequantially list condition		DUE TO		SEQUENCE OF								at llas
if any, leading to immed cause, Entar UNDERLYII	NG				,							12 yrs-
CAUSE (Disesse or inju- that initiated avents	y) '	DUE TO	OR AS A CON	SEQUENCE OF	F):							
resulting in death) LAST	۲ ()											
DADT ii Other election	at condition		4									
PART ii. Other significat	1 nn	2 contributing to	oaain bul n	ot rasuiting i	n the undar	lying caus	e given in	Part i.	24a. WAS AN PERFOR		24b.	
	UNI								1 YES 2	NO		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
								_			ı	
												AVAILABLE PRIOR TO COMPLETION OF CAUSE
DID TOBACCO US		IBUTE TO CA			_		NCERTAI					AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. P	LACE OF DEAD	(Check only o	one)		N 🗆				AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. P	LACE OF DEAD	CT HER:	one)	Residence	N 🔲				AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED CEXAMINER? 1 YES NO 27. MANNER OF DEATH 1 Natural 5 1	MEDICAL Pending	HOSPITAL:	26. P ER/Outputien	LACE OF DEAD	Check only of the control of the con	Home 5 L INJURY AT WORK?	Residence	N 🔲	(Specify)	NJURY OC	CCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED CEXAMINER? 1 YES NO 27. MANNER OF DEATH 1 Natural 5 1 2 Accident	MEDICAL Pending	HOSPITAL: 1 Inpatient 2 28e. DATE DF (Month, Di	26. P ER/Outpatien INJURY y, Year)	28b. TIMI	Check only of the control of the con	Home 5	Residence	N Desc	RIBE HOW I		11.	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED CEXAMINER? 1	MEDICAL Pending	HOSPITAL: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 28a. PLACE Of	26. P ER/Outpatien INJURY y, Year)	28b. TIMI	Check only of the control of the con	Home 5	Residence	8 Other 28d, DESC	RIBE HOW I		11.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 1 1 2 Accident 3 Suicida 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Pending nvestigation Could not be letermined	HOSPITAL: 1 Inpatient 2 28e. DATE DF (Month, Di 28e. PLACE Of building,	ER/Outputierr INJURY y, Year) F INJURY — A ttc. (Specify)	28b. TIM INJ	Check only in Hursing E OF URY M 1	Home 5	Residence	8 Other 28d. DESC	TION (Street of Town, State)	and Numbe	or or Rural A	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 1 2 Accident 8 0 4 Homicide 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Pending mvestigation Could not be letarmined	HOSPITAL: 1 Inpatient 2 28e. DATE DF (Month, Did building, DIAN: To the best of	26. P ER/Outputlen INJURY y, 'Year') F INJURY — A stc. (Specify)	28b. TIMI INJ	(Check only Check on C	Home 5	Residence NO No	8 Other 28d, DESC 281, LOCAL City or	FION (Street of Town, State)	and Numbe	or or Rural R	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED CEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 1 2 Accident 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Pending mestigation Could not be letarmined	HOSPITAL: 1 Inpatient 2 28e. DATE DF (Month, Did building, DIAN: To the best of	26. P ER/Outputlen INJURY y, 'Year') F INJURY — A stc. (Specify)	28b. TIMI INJ	(Check only Check on C	Home 5	Residence NO No	8 Other 28d, DESC	FION (Street of Town, State)	nner ee ata	or or Rural R sted. ha cause(s	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 I I 2 Accident 8 G 4 Homicide 8 G 29e. CERTIFIER (Check only one) 2 MEDIN 29b. SIGNATURE AND TIPCE	Pending meetigation Could not be fetarmined FYING PHYSIC CAL EXAMINES	HOSPITAL: 1 Inpatient 2 28e. DATE DF (Month, Di 28a. PLACE Of building, CIAN: To the best of	26. P ER/Outpatient INJURY y, 'ber') F INJURY — A ste. (Specify) may knowledge aminstion end	28b. TIMI 1 NJ t home, farm, e	Check only Hursing E OF 28c. URY M 1 partirest, fectory, in the time, in, in my opinion	Home 5	Residence 2 NO BCs, and due	8 Other 28d, DESC	FION (Street of Town, State)	nner ee ata	or or Rural R sted. ha cause(s	AVAILABLE PRIOR TO COMPLETION DE CAUSE DE DEATH? 1 YES 2 NO Noute Number,
25. WAS CASE REFERRED TO EXAMINER? 1	Pending meetigation Could not be letarmined IFYING PHYSIC CAL EXAMINER OF CENTIFIER	HOSPITAL: 1 Inpatient 2 28e. DATE DF (Month, Di 28e. PLACE Of building, CIAN: To the best of 8: On the basis of ex	26. P ER/Outpettern INJURY y, 'ber') F INJURY — A etc. (Specify) my knowledge amination end	28b. TIMJ 28b. TIMJ t home, farm, e , daeth occurre /or Investigatio	(Check only in the street, fectory, in the street, fectory, in the street, fectory, in, in my opinion in the street, fectory, in, in my opinion in the street, fectory, in the	Home 5 INJURY A WORK? YES office	Realdenca 2 NO Deca, and ductured at the	8 Other 28d, DESC	RIBE HOW I	nner ee ata d dun to t	or or Rural R	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number, and manner es stated.
25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNIER OF DEATH 1 Natural 5 II 2 Accident 5 II 3 Suicida 6 II 4 Homicide 6 29e. CERTIFIER (Check only one) 2 IMEDIC	Pending nvestigation Could not be letarmined IFYING PHYSIC CAL EXAMINER OF CENTIFIER DERSON WHO	HOSPITAL: 1 Inpatient 2 28e. DATE DF (Month, Di 28e. PLACE Of building, 28n. To the best of at the basis of experience of the building of the basis of experience of the building of the basis of experience of the basis of the basis of the basis of experience of the basis of t	26. P ER/Outpatien INJURY — A str. (Specify) my knowledge amination end E OF DEATH (6 1	28b. TiMind thome, farm, a death occurre for investigation (TEM 27) (Type, I Nur	Check only Hursing E OF 28c. URY M 1 partirest, fectory, in the time, in, in my opinion	Home 5 INJURY A WORK? YES office	Realdenca 2 NO Deca, and ductured at the	8 Other 28d, DESC	RIBE HOW I	nner ee ata d dun to t	or or Rural R sted. ha cause(s	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number, and manner es stated.
25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 1 NO 27. MANNER OF DEATH 1 Natural 5 1 2 Accident 3 Suicide 8 0 4 Homicide 8 0 29e. CERTIFIER (Check only one) 2 MEDIU 29b. SIGNATURE AND TIPCE 30. NAME AND ADDRESS OF DY . Majoue 1	Pending nvestigation Could not be letarmined IFYING PHYSIC CAL EXAMINER OF CENTIFIER DERSON WHO	28e. DATE DF (Month, Di Dell'Aller) 28e. PLACE OI building, CIAN: To the best of a: On the basis of ex COMPLETED CAUS SEVIIIa 32. REGISTRAL	26. P ER/Outpatien INJURY — A str. (Specify) my knowledge amination end E OF DEATH (6 1	28b. Time in No. 1 to the course of the cour	(Check only in the street, fectory, in the street, fectory, in the street, fectory, in, in my opinion in the street, fectory, in, in my opinion in the street, fectory, in the	Home 5 INJURY A WORK? YES office	Realdenca 2 NO Deca, and ductured at the	8 Other 28d, DESC	RIBE HOW I	nner ee ata d dun to t	or or Rural R	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number, and manner es stated.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

	REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR										
	Conan W	att Burtr	am Barge	r		Oct 28,19	8:30 A M				
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7 DATE OF BIRTH		THPLACE (State or Foreign			
	509-10-2539		88 YRS.	MONTHS DAY		(Month, Day, Year)	Cou	ntry)			
	9a. FACILITY NAME (If not institution, give st			Ab (0177) ==			1907 Iov				
œ	Pineview Rehab.			Clir	N OR LOCATION OF D	EATH	9c. COUNTY OF				
2	RESIDENCE OF DECEDENT	Cerreer		CLII	10011		Prince	George's			
E	10a. STATE 10b. COUNTY		10c CIT	Y, TOWN OR LO	CATION						
E	Managara Barbara		7.6		2000			10d. INSIDE CITY LIMITS?			
<u> </u>	Maryland Prince	ce George's		Distric	t Heights			1 TYES 2 NO			
AA	6612 Foster Stree	2 +			10f. ZIP CODE			WHAT COUNTRY?			
FUNERAL DIRECTOR					2074	7	United	d States			
5	11. MARITAL STATUS	12. WAS DECEDENT EVE		13. WAS (ECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14. RA	CE — Americen indian, ick, White, stc.			
ВУ	1 Never Married 2 Married WW Wildowed 4 Divorced	FORCES? 1 Y	R DATES	1 🗆 1	specify Cuban, Mexico	y:		eck, writte, stc.			
	121						Whit	ce			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade)	CATION completed)	16a. DECEDENT'S	USUAL OCCUPY	TION	16b. KIND OF BU	SINESS/INOUSTRY				
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)	mode or working						
A P	12	5	Foreign	n Broad	cast Moni	tor Feder	al Gover	nment			
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surneme)				
BE (Wyatt Burtram F	Barger			Eliza	beth Marro	Ka7				
	19e. INFORMANT'S NAME (Type/Print)	202	19b, MAJLING	ADDRESS (Stre		Aoute Number, City or Tow					
임	C.W. Bruce Barger	_				Clinton,Ma		20735			
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE			OATE 20c. LO					
	1 X Buriel 2 Cremetion 3 Remo	wal from State	cemetery, crematory or o	her place)	(Name of	OATE 20c. LO	CATION — City or	Town, State			
	4 Donetion 6 Other (Specify)	ENOSE .	<u>Cedar Hil.</u>	L Cemet	ery Nov 1	,1995 Sui	tland, N	Maryland			
	22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 663										
	10t 5 5	it.		Old	Alexandri	a Ferry Ro	ad, Clir	nton, Md 20735			
	23. PART i. Enter the disesses, or co	omplications that cau	sed the deeth. Do n	of enter the	node of dylna euc	h ea cardleo or mon	ireton, ornat	Approximate			
	snock, or heart failure. List only one cause on each line.										
	IMMEDIATE CAUSE (Finel										
	reaulting in death) Severe Coronary Artery Disease										
ŀ	DUE TO (OR AS A CONSEQUENCE OF):										
Z.	Sequentially list conditions, Calcific Aortic Stenosis										
CERTIFICATION	if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE OF	7:							
2	CAUSE (Disease or injury		General	ized Ar							
쁜	thet initieted events	DUE TO (OR A	S A CONSEQUENCE OF	7:							
H	resulting in death) LAST										
	PART II. Other eignificant conditions	contribution to deat	hut not condition !	- ab							
EDICAL	TAIT II. Other eighticals conditions	contributing to deen	but not reculting i	n the underly	ing ceuse given in	Part I. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO			
ă						1 X YES 2	NO	COMPLETION OF CAUSE OF DEATH?			
₩						'		1 YES 2 NO			
	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YE	S NO	☐ UNCERTAII	۷ 🗆 📗		^			
×.	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	H (Check only or	ne)						
S		HOSPITAL: 1 inpetient 2 ER/0	utpatient 3 1 DOA	OTHER:	ome 5 🗆 Residence	& [] Other (015.)					
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF INJUR	Y 26b. TIM		NJURY AT	28d. DESCRIBE HOW I	MINEY OCCUPED				
	1 Netural 5 Pending	(Month, Day, Yea		URY	WORK?	DEGUNIDE NOW I	TOTAL OCCUREO				
BY	2 Accident investigation	200 01 405 05 01 01	leny As have a								
0	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (S	IRY — At home, farm, a pecify)	treet, factory, of	fice	261. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,			
COMPLET	29a. CERTIFIER Check only	IAN: To the best of my kn	owledge, desth occurre	d at the time, d	ite and place, and due	to the cause(a) and mar	nner as stated,				
8	one) 2 MEDICAL EXAMINER							(a) and menner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER							27. 1.2. 1.2. 1.2. 1.2. 1.2. 1.2. 1.2. 1			
H	D. D. e. X T.	1 4200	O. M. 7)_	29c. LICENSE NUI	MBER /	29d. OATE SIGNE	D (Month, Day, Year)			
2	20 NAME AND ADDRESS STATES	4. CECC	21111	1	12/13	956 enter Ch	CCC	Der 34/1995			
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type,	Print)	11 10	- / N	- 0 /	> /			
	Robert Hi Koe	MI, MIL	Mince GE	eorge's	Hospital L	enter Ch	everly,	M.D.			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE WELSON RONDAL								
	NOV () (199)) Helen don	valer Tantal	f.							

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

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	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	EDITH CATHERI	NE BEERS				October 2	9.1995	1:30 A M		
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. 1	BIRTHPLACE (State or Foreign		
	214-46-6309		2 YRS.	NONTHS DAYS	HOURS MIN.	Dec. 20,		irginia		
	9a. FACILITY NAME (If not institution, give st			9b. CITY, TOWN O	R LOCATION OF	DEATH	OF DEATH			
DIRECTOR	Holy Cross Hospital Silver Spring Montgome									
Б	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	10c CITY	TOWN OR LOCATI	000					
E	Maryland Princ	e George's	Ade1		ON			10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	c dearge a	Adei		ZIP CODE		10a CITIZEN	1 ∑ YES 2 ☐ NO OF WHAT COUNTRY?		
1	1801 Metzerott R	oad		2	0783		U.S.A			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED			NIC ORIGIN? (Specify Ye		RACE - American Indian.		
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 XINO	If yes, spe	city Cuban, Maxic 2 🔯 NO Spec	en, Puerto Rican, atc.)		Black, White, etc. Specify:		
	**							White		
日日	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of wo	rk done during mos	N t of working	16b. KIND OF BU	SINESS/INDUST	RY		
2	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Itte. Do NOT use							
COMPLET	17. FATHER'S NAME (First, Middle, Lest)		Homemake	r		Own Hot AME (First, Middle, Malden				
	(Unknown) Clevel	and			(Unknow		Sumame)			
BE	19a. INFORMANT'S NAME (Type/Print)	3110	19b. MAJLING A	DDRESS (Street an		W11) I Route Number, City or Tow	un State Zin Cod	(4)		
은	J. William Beers									
	2Qa. METHOD OF DISPOSITION	20b	PI ACE AND DATE OF	DISPOSITION (Non	ne of	DATE 200 LC	CATION CIN	as Town Chats		
	1 🖾 Buriel 2 🗆 Cremation 3 🗆 Remo	vel from State com	etery, crematory or other	Cemeter	v 11	/01/95 Sui	tland.	Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AND	ADDRESS OF F	ACILITY				
	W.B. G.					h's Sons Fu		Home, P.A. 11e, MD 20781		
	23. PART I. Enter the disesses, or c	omplications that caused	the desth. Do no	t enter the mod	e of dying, su	ch as cardisc or resp	iratory arrest,	Approximata		
	immediate Cause (Final disease or condition	List only one cause on e	ach line.	0				Interval Between Onset and Death		
	resulting in death)	DUE TO JOB AS A	CONSEQUENCE OF	paeu	Delu	_		say		
_	_	a Air	- 24	2.00	n. Du	ora Doa	~			
힐	Sequentially ilst conditions,	DUE TO (OR AS A	CONSEQUENCE OF):	1		341				
3	cause. Enter UNDERLYING CAUSE (Disease or injury									
FI	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	resulting in death) CAST	4								
AL C	PART II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	csuse given in	Part i. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
	arbersoll	look Card	walls and	2 Des	cesa	PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
율						1 YES 2	N _{NO}	OF DEATH?		
=	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES	□ № □	UNCERTAI	N R		1 TYES 2 NO		
N N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH							
Si	1 TES 2 ZHO	HOSPITAL: 1 ☐ Inputient 2 ☐ ER/Output		OTHER:	5 Residence	8 Other (Specify)				
PHYSICIAN: MEDIC	27. MANNER OF BEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME (RY AT	28d. DESCRIBE HOW I	NJURY OCCURE	D		
ВУ	1 Natural 5 Pending 2 Accident Investigation				S 2 NO					
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	- At home, term, stre	eet, factory, office		281. LOCATION (Street a City or Yown, State)		ural Route Number,		
COMPLETED										
립		CIAN: To the best of my knowle								
Š	one) 2 MEDICAL EXAMINER	t: On the basis of exemination	and/or investigation,	In my opinion, des	ith occured at the	time, date and place, an	d due to the cau	use(s) end menner es stated.		
ш	29b. SIGNATURE AND TITLE OF CONTINER	to .			29c. LICENSE NU	MBER	29d. DATE SIG	INPO (Month, Day, Year)		
TO B	mylas X. a	eaken 4	,	4	2066	74	10/	29/5		
	30. NAME AND ADDRESS OF PERSON WHO CO.	LENKIN	TH (ITEM 27) (Type, PI	rint)	2309	SHOREFI	20	120		
	31. DATE FILED (Month, Day, Year)	37 REGISTRAR'S SIGN			CIN.	EHTON !	2			
	AA' DA DOO	(/								

BALTIMORE. MARYLAND 21215-0020

DIVISION OF VITAL RECORDS. P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. P	be filed within 72 hours after death with the State Dept; of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTEN	TO THE FUNERAL DIRECTOR:	be filed within 72 hours after	IMPORTANT: If item 28 i

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE 1 -CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OEATH 1955 **JAMES** ARNOLD BERGMANN ΦCTÖBER 21:48 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) F UNDER 1 YEAR | IF UNDER 24 HRS. 7 DATE OF BIRTH 5. SEX B. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN 1 X M 2 - F 48 YRS 217-44-9633 Jan. 11, 1947 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 4103 METEZROTT ROAD COLLEGE PARK DIRECTOR PRINCE GEORGES RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 NO Prince George's Maryland College Park FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP COOR 4103 Metzerott Road 20740 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION 16a. OECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Construction 4 Carpenter 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Milton Herman Bergmann Betty Lee Marker BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Frances M. Bergmann 4921 Lexington Avenue, Beltsville, Maryland 20705 20a. METHOD OF DISPOSITION
1 ☑ Burlei 2 ☐ Cremation 3 ☐ Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE Fort Lincoln Cemetery 11/01/95 4 Donation 5 Other (Specify) Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fallure. List only one cause on sech line Onset and Dasth IMMEDIATE CAUSE (Fine) disease or condition SHOTGUN WOUND OF HEAD recuiting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentisity list conditions. OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IN UNCERTAIN I 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL 1 TYES 2 NO HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Homa 5 🔂 Rasidenca 6 ☐ Other (Specify) 27. MANNER OF OEATH 28a, OATE OF INJURY 28c. FIME OF INJURY OF IN 28b, TIME OF 28c. INJURY AT WORK? 28d OFSCRIBE HOW INJURY OCCURED 1 Natural SUBJECT SHOT SELF BY 2 Accident
3 Sulcide
4 Homicide Investigation 281. LOCATION (Street and Number or Rural Route Number, MD City or Town, State) 410 3 METEZROTT RD, COLLEGE PARS 8 Could not be determined COMPLETED Home 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) restigation, in my opinion, death occured at the time, data and place, 2 MEDICAL EXAMINER: On and due to the cause(a) and manner as stated 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) SIGNATURE AND TITLE OF CERTIFIES 8 **OCTOBER 28 1995** O.C.M.E. 2 (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 GOLLE JR

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within "hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: It leam 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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	REGISTRAN		- OL	THIT	AIL OI	DLA		HEG. NO.					
à.	1. DECEDENT'S NAME (First, Middle, Lest)			DAY YEAR		3. TIME OF DEATN							
- 1		con						October 28	3, 19		3:15 A M		
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. last		F UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		Country			
	156-26-5025	1 X M 2 🗆 F	59	YRS.				09-06-36		New	Jersey		
	Se. FACILITY NAME (If not institution, give s	street and number)		9	9b. CITY, TOWN OR LOCATION OF DEATN 9c. CC					TY OF DE	ATH		
E I	1611 Elkwood Coa	ırt			Annap	olis			Ann	e Ar	undel		
5	RESIDENCE OF DECEDENT									- 1			
DIRECTOR	10a. STATE 10b. COUNT	Y		10c. CITY,	TOWN OR LOC	ATION					10d. INSIDE CITY LIMITS?		
		e Arundel		Ann	apolis						1 X YES 2 NO		
4	10e. STREET AND NUMBER				1	of. ZIP COD	E		10g. CITI	ZEN OF W	HAT COUNTRY?		
FUNERAL	1611 Elkwood Cou	ırt				21401				US	A		
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARN	MED				NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No —	14. RACE	- American Indien, White, etc.		
	1 Never Married 2 Merried	IF YES, GIVE Y	MAR OR DATES	0		S 2 T NO				Specif			
ВУ	3 Widowed 4 Divorced	1954	-1958								White		
	15. DECEDENT'S EDU (Specify only highest grade		18e. DEC	CEDENT'S US	BUAL OCCUPAT	TON	na	16b. KIND OF BUS	SINESS/IND	USTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Do NOT use	retired.)								
MP	12	4	Per	sonne	1 Spec	ialis	st	Federal	l Gov	ernm	ent		
COMPLETED	17. FATNER'S NAME (First, Middle, Lest)	10				18. MOT	NER'S NA	AME (First, Middle, Maiden	Surname)				
BEC	Herve Lucien Bar	ron				Ma	rie	Jeanne 1	Ranno	u			
	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING A	DDRESS (Street	end Number	r or Runal	Route Number, City or Tow	n, State, Zip	Code)			
5	Adele Baron		16	11 E1	kwood	Court	An	napolis, Ma	aryla	nd 2	1401		
	20a. METHOD OF DISPOSITION		20b. PLACEA	ND DATE OF	DISPOSITION	Vame of		DATE 20c. LO	CATION -	City or Tox	vn, State		
	1 Burial 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	noval from State	Lakemo	natory or othe	morial	Gard	lens	10-30-95 1	David	sonv	ille. Md.		
	1 Departure of Funeral Service Licensee 1 Departure of Funeral Service Licensee 2 Name and Address of Facility 2 Name and Address of Facility												
	200000	-			Robert E. Evans Funeral Home, P.A.								
	Lopping E.	wans									yland 20715		
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) s. Adamocarci no man of Colon								Intervel Between Onset and Death				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												
	PART II. Other significent conditio	ns contributing to	deeth but not re	eeulting In	the underly	ng ceuse	given ir	Part I. 24e. WAS AN		24b.	WERE AUTOPSY FINDINGS		
EDICAL								PERFOI			AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ED								TO TES	E NO		OF DEATH?		
Σ	DID TOPACCO LISE CONT	DIDLITE TO C	VIISE OF DEAT	TLI VEC	T NO		CEDTAI	N D			1 YES 2 P NO		
Z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	20.72-0		OTHER:		,						
YS	1 TES 2 NO		☐ ER/Outpatient 3				eeldenca	6 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH 1 Neturel 8 Pending	28a. DATE O (Month,	F INJURY Day, Year)	28b. TIME INJU	RY	NJURY AT VORK? YES 2 [NO	28d. DESCRIBE NOW	INJURY OC	CURED			
ВУ	2 Accident Investigation 3 Suicide B Could not be	28e, PLACE	OF INJURY — At hor	me, ferm, st				281, LOCATION (Street	and Number	or Rural F	loute Number		
ED	3 Suicide 8 Could not be 4 Nomicide determined	building	, atc. (Specify)		,			City or Town, State,					
	290. CERTIFIER			35	32 53								
MP	one)							e to the ceuse(a) and ma			Carrier Linear		
COMPLET	2 MEDICAL EXAMIN	EH: Of the beste of	examination end/or i	investigation	, in my opinion	, death occu	ired at th	e time, date end place, er	nd due to tr	ne ceuse(e) end manner ae stated.		
BE (296. SIGNATURE AND TITLE OF CERTIFIE		\			29c. LIC	Z C	IMBER X	29d, DAT	E SIGNED	(Month, Day, Year)		
10	CO HAME AND ADDRESS OF BERSON W	A C	J	4.07. (7	Defent.	10 -	00	000	1 - (10	- (13		
	10. NAME AND ADDRESS OF PERSON W	MO COMPLETED CA	180	127) (Typo, 1	Print)	Co	chi	rave Di	ve	An	napilia		
	31. DATE FILED (Month, Day, Year) NOV 0 1 1995	32/REGISTE	AR'S GIGNATURE	dall									
	140 A O T 1222	7											

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DALLINONE, MANILAIN	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hos	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT; It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. DOA 507 OF	The	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	Item
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	. SIAIL			MENT OF HEALTH AND	MENTA		E		
_	REGISTRAR	CE	RITE	CATE OF DEATH		REG. NO.			
;	Josephine J.	Ben-Shr	nuel		OC t	of OEATN DA	Ĭ995	VEAR	D:25 P. M
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. lest		IF UNDER 1 YEAR IF UNDER 24 HRS.	7 DATE	OF BIRTH		S. BIRTNPLA	CE (State or Foreign
	121-09-0108 1 M 2 🖫	91	YRS.	MONTHS DAYS HOURS MIN.		30,		New 1	
œ		020		9b. CITY, TOWN OR LOCATION OF I			l .		
0	Carriage Hill Nursing H	Jille		Silver Spring	3		Mont	gomer	/
DIRECTOR	10s. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCATION				100	I. INSIDE CITY
ā	Maryland Montgomery		S	ilver Spring				X	YES 2 NO
A.	10e. STREET AND NUMBER			101. ZIP CODE			10g. CITIZ	EN OF WHAT	COUNTRY?
E	1316 Fenwick Lane			20910				USA	
FUNERAL	EODCES2	DENT EVER IN U.S. ARI	MED	13. WAS DECENDENT OF NISP. If yes, specify Cuben, Mexic			or No-	14. RACE — Black, W	American Indian, hita, atc.
BY F		E WAR OR DATES		1 TES 2 NO Spec		rescart, wed.;	- 1	Specify:	
				<u> </u>	T		1		Vhite
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Gi	ve kind of w Do NOT use	JSUAL OCCUPATION ork done during most of working	166	KINO OF BUS	SINESS/IND	USTRY	
3	Elementary/Secondary (0-12) College (1-4 or 12th	5+)				Α .			
COMPLETED	17. FATNER'S NAME (First, Middle, Last)	ISCU.	LDLOL	and Weaver	IAME /First	Ari			
	William Pearson	Toples			,,		,		
H	19s. INFORMANT'S NAME (Type/Print)		. MAILING	ADDRESS (Street and Number or Rure		ohnes (Code)	
2	Penny W. Caccavo	13	23 Wi	llow Street Ro	nel wn	Height	te N	Y 11	577_1215
1	20a. METHOD OF DISPOSITION			F DISPOSITION (Name of	DAT	E 20c. LO	CATION —	City or Town,	State
	1 Buriel 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cred	metory or oth	tan Crematory 1		- 1			
	21. SIONATURE ON FUNERAL BETTY CE LUCENBEE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22. NAME AND ADDRESS OF I	FACILITY				11.511114
	>1/1/10/11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1			George P. Ka					007/5
-	23. PART I. Entar the diseases, or complications	that caused the de	eth Don	6160 Oxon H					Approximate
	shock, or heert fellure. List only one			or enter the mode of dying, at	zen ea can	unac or reap	natory arr	eet,	intervai Between
- 1	IMMEDIATE CAUSE (Finel disease or condition	0 0	-10	Domontia					Onset and Death
	reculting in death)	TO (OR AS A CONSEC	SUS /	Delilelicia					
	- Alm	nha	JOENOL OF	·					ĺ
CERTIFICATION	Sequentially liet conditione,	TO (OR AS A CONSEC	GUENCE OF):					
F.	If any, leading to immediate cause. Enter UNDERLYING								
프	CAUSE (Disease or injury that initiated events	TO (OR AS A CONSEC	DUENCE OF):					_
F	resulting in death) LAST								
2	PART II. Other aignificent conditions contributing	to death but not a	andelma I	n the underlying sever given	in Dart I	DATE MED AN	ALTTORAN	0.45 W	RE AUTOPSY FINDINGS
3	PART II. Other aignificent conditione contributing	to deem but not i	eeuitiiig i	i the underlying cause given	m rant.	PERFOR	RMED?	AW	MILABLE PRIOR TO MPLETION OF CAUSE
ă						1 TYES 2	NO		DEATH?
ME				- C 110 C 11110555				1 [YES 2 NO
Ä	DID TOBACCO USE CONTRIBUTE TO			S NO UNCERTA	IIN L				
0	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL	:		OTHER:					
PHYSICIAN: MEDICAL		2 ER/Outpatient 3 OF INJURY	28b. TIMI	4 (△ Nursing Nome 5 ☐ Residence	_	er (Specify) SCRIBE NOW I	IN HIEV OCC	CUBED	
		th, Day, Year)	INJ		200. DE	SCHIBE NOW	INJUNT OCC	JONED	
ВУ	2 Accident Investigation	E OF INJURY — At ho	me ferm e		281 LO	CATION (Street	and Number	or Bural Bout	n Number
TED	3 Suicide 6 Could not be build	ling, atc. (Specify)				or Town, State)		J. 7 M. di 7 1001	
9	290. CERTIFIER 1 CERTIFYING PHYSICIAN: To the be	nt of my knowledge de	ath occurre	d at the time, date and place, and d	lun to the co	use(s) and me	nner en elet	ed.	
COMPLETE	(Check only one) 2 MEDICAL EXAMINER: On the beels								d manner se stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER								onth, Day, Year)
BE	m7	THERE	SA G.	MCLAUGHLIN, M.D.	2010			0/20	

THERESA G. MCLAUGHLIN, M.D. NUMBER 29d. DATE SIGNED (Month, Day, Year) TAX ID. NO.-167-56-1172 435 10

10/30

Theresa G. McLaughlin. M.D. 8700 Georgia Ave. Suite 400 Silver Spring. Md

31. DATE FILED (Month, Day, Year)

22. REGISTRAR'S SIGNATURE

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State of the sales

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ospital or attending physician. The for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ex-nours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

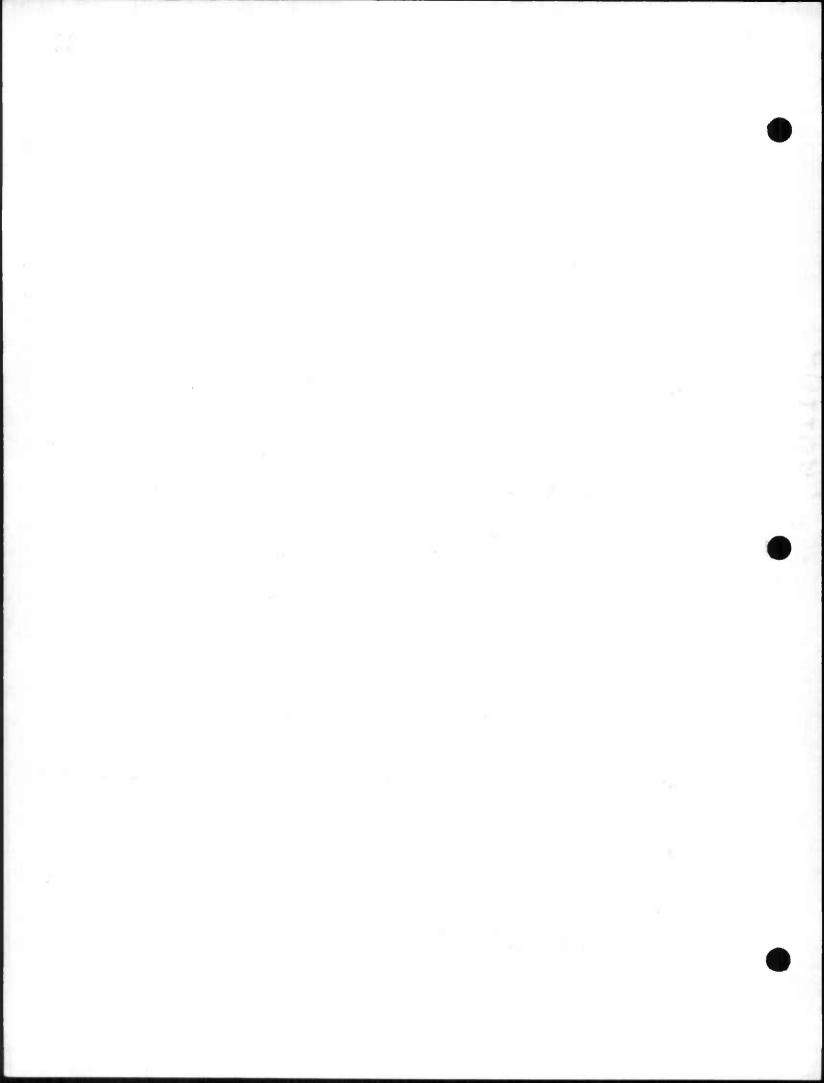
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND			F HEALTH			YGIENI EG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH		3.	TIME OF OEATH
- 1	LAWRENCE BURGOON	BANKERT				- 1	NOV.	6, 1	995	YEAR	1:10 A M
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs.	last birthday)	IF UNDER 1 Y			7. DATE OF BI (Month, Day	RTH		. BIRTHPLA Country)	ICE (State or Foreign
	185-01-7803	₩2 □ F 8	1 YRS.	MONTHS D	HOURS	MIN.	voust.		1914	Mary	land
	9a. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TO	WN OR LOCATI				9c. COUNT	Y OF DEAT	Н
DIRECTOR	Westminster Nursing	//Convalescent	Ctr.	We	stmins	ter			Car	roll	
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY	TOWN OR L	OCATION	-				100	d. INSIDE CITY
E	Maryland Ca	errol1		Vestmi							LIMITS?
	10e. STREET AND NUMBER	11011		VCD CITIZ	10f, ZIP COD	E			10g. CITIZE		T COUNTRY?
FUNERAL	116 Highland Road				2115	7			Unit	ted S	tates
2	11. MARITAL STATUS 12	. WAS DECEDENT EVER IN U.S.			OECENDENT O	OF HISPANIC				4. RACE —	American Indian.
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES 23	NO		n, specify Cubi YES 2 🙀 NO		Puarto Rican,	etc.)		Black, Wi	hita, atc.
										Whit	e
	15. DECEDENT'S EOUCATI (Specify only highest grade com	npleted)	OECEDENT'S (Give kind of w life. Do NOT use	ork done durir	PATION g most of working	ng	16b. KIND	OF BUS	INESS/INOUS	STRY	
7	Elementary/Secondary (0-12) C	college (1-4 or 5 +)		Lright			E	ecto	1- 37		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)		1711	LLIGHT		HER'S NAM	E (First, Middle	_	-		
	Manias Vincent Bank	rert.					ola Bu				
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St	reet and Number			10,07		iode)	
2	L. Brian Bankert		49½ Ca	arroll	Stree	t, We	stmins	ster	, MD	2115	7
	20a. METHOD OF DISPOSITION 1 Duriel 2 M Cremation 3 Removal		EANDDATEO				OATE	20c. LO	CATION - CI	ly or Town,	Stata
	4 Donation 5 D Other (Specify)	Cari	COLI C	_				Ham	pstea	d, Ma	ryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS	IN O	. /		rs Fun						
	Julanot	slachonte	Hue					estm	inste	r, MD	211.57
	23. PART i. Enter the diseases, or com shock, or heert failure. List	plicetions that caused the	death (Do n	ot enter the	mode of dy	ing, such	as cerdiec d	or reepi	retory erres	st,	Approximata
	IMMEDIATE CAUSE (Final	Only one couse on each in	ne. 0	15	1						Onset and Death
1	disease or condition resulting in deeth) e	acule se	nal	fee	wen	e.					20年8
		OUE TO (OA AS A CONS	SEQUENCE OF	111-	A	-					DUENA
ON	Sequentially list conditions, b.	OUE TO (OR AS A CONS	SEQUENCE OF	DULL	lis	11	yke	11			SYLMO
CERTIFICATION	if any, leeding to immediate cause. Enter UNDERLYING		24021102 01	,.		1					
Ē	CAUSE (Diseese or injury that initiated evente	DUE TO (OR AS A CONS	SEQUENCE OF):							
ERT	resulting in deeth) LAST										
- 11	PART II. Other significent conditions co	ontributing to deeth but no	t resulting la	the under	iving ceuse (niven in P	art I 24a	WAS AN	AUTOPSY	245 WE	RE AUTOPSY FINDINGS
CAL	arthur				ying could	g. v o i i i i i		PERFOR	MED?	AVA	MABLE PRIOR TO
						,	_ ' -	YES 2	□ NO	OF	DEATH?
≥	DID TOBACCO USE CONTRIB	UTF TO CAUSE OF DE	ATH YE	S D NO	IV LINC	ERTAIN	_ [_			1 1	YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		ACE OF OEATI			LKIAII	<u> </u>	-			
Sic		OSPITAL: Inpetiant 2 - ER/Outpetiant	3 DOA	OTHER:	Home 5 🗆 Ra	ssidence 8	Other (Spe	cifv)			
PHYSICIAN: MEDIC	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 286	INJURY AT WORK?	- V	28d. DESCRIB		JURY OCCU	RED	
BY	1 Netural 5 Pending 2 Accident Investigation				YES 2] NO					
	3 Suicida 8 Could not be determined	28s. PLACE OF INJURY — At building, atc. (Specify)	home, term, st	reet, tactory,	offica	2	281. LOCATION City or Tow		nd Number or	Rural Route	Number,
COMPLETED		: To the best of my knowledge,									
į	2 MEDICAL EXAMINER: O	in the basis of examination and/o	or investigation	, in my opini	on, death occur	red at the tir	me, deta and p	placa, and	due to the	cause(s) and	d manner as stated.
H	296. SIGNATURE AND THILE OF CERTIFIER	1/2/1/10	Λ	1	29c. LICI	ENSE NUMB	ER COOL		29d. DATE S	SIGNEO (Mo	nth, Day, Year)
0	James IV	verelle	IV	1-1/	12	111	744	2	> //	16-6	16
	30. NAME AND ADDRESS OF PERSON WHO CO				3 **	,		-	0115	-,	
	Dr. Daniel I. Welli	iver 912 Was		on Roa	a, Wes	tmins	ster, l	MD	2115	/	
	NOV 8 1995	Julia Dhuilean									
	0 1995	Juna arminar	adall								

BALTIMORE, MARYLAND 21215-0020	. Page 6 may be retained by the hospital or attending physician.
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VITAL RECORDS, P.O. BOX 687	TTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If tem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART CERTIFIC			MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	LARON	V.	BROOK	S		OCT 19			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIF	THPLACE (State or Foreign	
	219-21-0235 9e. FACILITY NAME (# not institution, give st	t X M 2 F	6 YAS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) Dec. 21, 1	988 Ma:	ryland	
OH	HOBBS ROAD NEAR SUBSTATION			DENTON		AITI	CAROLINE		
ᇤᅵ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	10c, CITY.	TOWN OR LOCAT	ION			10d. INSIDE CITY	
DIRECTOR		roline	De	enton				LIMITS?	
FUNERAL	10e. STREET AND NUMBER			1000	ZIP CODE		7.5	F WHAT COUNTRY?	
岁	404 Riverview Ga				21629		USA		
5	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES				HC ORIGIN? (Specify Yee n, Puerto Rican, etc.)	or No 14, R/Bi	ACE — American Indian, lack, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 TYES	2 X NO Specify	y:	Sp	Black	
	15. DECEDENT'S EDUC	CATION	16e. DECEDENT'S U	SUAL OCCUPATION	N	16b, KIND OF BUS	I INESS/INDUSTRY		
<u> </u>	(Specify only highest grade Elementary/Secondery (8-12)	College (1-4 or 5+)	(Give kind of wo	rk done during mo: retired.)	st of working	1=0.00			
릴	Kindergarden		Stude	ent		Stu	dent		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surneme)		
BE	Rodney P.Brooks	3			Valer	ie D. Wayma	an		
2	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Town			
٦	Valerie D. Wayma	ın	. 404	Rivervi	.ew Garde	ens, Dentor	1, Md. 2	21629	
	20e. METHOD OF DISPOSITION 1 Burlet: 2 Cremation 3 Remote	oval from State	ob. PLACE AND DATE OF emetary, crematory or othe Capitol Cr	DISPOSITION (Na ar placa) ematory		0/24/95 Do	cation - city or ver, De		
	21, SIGNATURE OF FUNERAL SERVICE LIC			22. NAME AN	D ADDRESS OF FA	CILITY			
	Dun A 2	unce				th Funeral 687, Easto			
NO	23. PART Enter the diseases, or cenock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	a. DUE TO (OR AS	aech lina.	IN	de of dying, suc	h aa cardiac or reepi	ratory arrest,	Approximata Interval Batween Onset and Death	
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente rasulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
PHYSICIAN: MEDICAL	PART II. Other significant condition	e contributing to deeth	but not resulting in	the underlying	g cauaa givan in	Pert I. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 \(\text{NO} \) NO	
ž	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YES	ON C	UNCERTAI	N 🗆		^	
N S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH						
1,SE	1 🙀 YES 2 🗌 NO	1 Inpetient 2 ER/O		OTHER: 4 Nuraing Hom	e 5 🗆 Residenca	6 X Other (Specify)	AT SCE	NE	
F	27. MANNER OF DEATH	26a. DATE OF INJUR (Month, Day, Jean			URY AT RK?	28d DESCRIBE HOW I	NJURY OCCURED	+ 11/	
B	1 Natural 5 Pending 2 Accident Investigation	10/19/9	5 0030			laserge,	- Nau	DO-CCIOSOT	
	3 Suicide 8 Could not be 4 Homicide determined	26e. PĽACE OF INJU building, etc. (S)	RY — At home, form, at Decity) STREE	reet, tactory, offic		261. LOCATION (Street in City projown, State)	and Number or Ru	ral Route Number,	
COMPLETED	(con)	ICIAN: To the best of my kno				to the cause(e) end mer		110	
S	2 X MEDICAL EXAMINE	ER: On the beels of exeminar	tion end/or investigation	, in my opinion, d	eath occured at the	time, date end place, en	d due to the ceu	se(e) end menner ee stated.	
BE	294 SHANATURE AND TITLE OF CERTIFIES	A L	^		29c. LICENSE NUI	MBER	29d. DATE SIGN	NED (Month, Day, Yeer)	
2	June	repm			O.C.M	.E.	OCT	19, 1995	
-	JAARON (O	AAA.			, Balt	imore, Ma	rvland	1 21201	
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SI					,		



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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 has fluct writin 72 hours after neath with the State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal.	to not marked as the market of the market of the market of the formal the market available much be marketed of once
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- STATE REGISTRAR	STATE OF MARY			OF DEAT		REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)					2. I	DATE OF DEATH	AY	YEAR	3. TIME OF DEA	TH
4. SOCIAL SECURITY NUMBER 5.		RINGER E. (In vrs. lest birthdev)) IF UNDER 1 YE	EAR IF UNDER 2		OVEMBER	3, 1	995	5:30 HPLACE (State or F	P W
233-44-5090	□ M 2 🎇 F	71 yrs.	MONTHS DA	AYS HOURS	™. Sé	pt. 20, 1		Wes	St Virgi	
99. FACILITY NAME (# not institution, give street Sacred Heart He RESIDENCE OF DECEDENT				erland	OF DEATH			legar		
10e. STATE WV Hamps!	hire		Spring				10d. INSII LIMI 1 YES			
HC 81, Box 30				101. ZIP CODE 26763				J.S.A	WHAT COUNTRY?	
11. MARITAL STATUS 1	R IN U.S. ARMED S 2 XNO DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yell fit yea, apacity Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:								
(Specify only highest grade con	15. DECEDENT'S EDUCATION (Specify only highest grade completed) mentary/8-condary (0-12) College (1-4 or 5 +) The decedent's USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.)					16b. KIND OF BU	siness/in			
17. FATHER'S NAME (First, Middle, Last)	Moreland			18. MOTHE	ER'S NAME (First, Middle, Maiden Marie S	sumeme) tewa	rd		
190. INFORMANT'S NAME (Type/Print) David E. Haines		196. MAILIN 3625	Taneyt	treet end Number of	or Aural Route	Number, City or Tow ettsburg	wn, Stete, Zio Code) g, PA 17325			
20e. METHOD OF DISPOSITION 1 Cyburles 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Commetter), cremetory, cremetory or other place) 4 Ponetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Commetery, cremetory or other place) Sunset Memorial Park Nov. 6,1995 Cumberland, ME									B	
21. SIGNATURE OF FUNERAL SERVICE LICEN	M SEE	/ _	22. NAI	me and adorest affer F	OF FACILIT	1 Home	Tnc		- 1	
23. PART I. Enter the diseases, or con ahock, or heart failure. Lis			23	80 East	Main	St., Rom	ney,	WV	26757	
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ahock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS	S A CONSEQUENCE S A CONSEQUENCE S A CONSEQUENCE	Denot anter the OF):	BO East a moda of dyin	Main Ig, auch aa	St., Rom	Hen	WV rreat,	Approximinterval E Onset an Competition of Death?	etweed Dael
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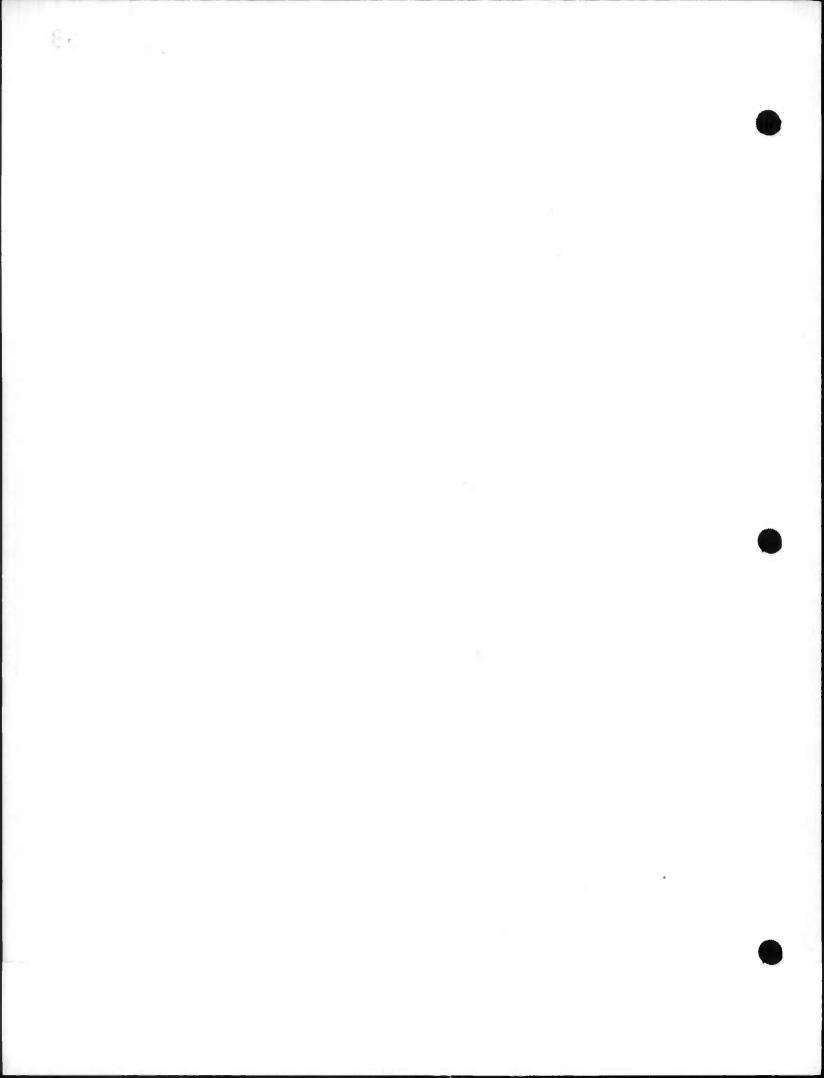
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE OF M			MENT OF H	EAUTH AND	MENT	AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATH		VE LE	3. TIME OF OEATH
	ELIZABETH MARIE BOTTI					NÖV	EMBER 2	, 19	9 ^{YEAR}	8:15 Pm
	169-14-7884 1□ M 2 🖾 F	6. AGE (In yrs. les	"//	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT (Mo SEP	E OF BIRTH ofth, Day, Year) T 25,	2 192 %	8. BIRTNI Country PA	PLACE (State or Foreign y)
OR	96. FACILITY NAME (If not institution, give street and number) 475 DENNETT ROAD OAKLAND								RRET	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c, CITY, 1	TOWN OR LOCAT	ION			10d, INSIDE CITY			
	MARYLAND GARRETT	OAKLAND							LIMITS?	
ĭĀL	10e. STREET AND NUMBER			10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	475 DENNETT ROAD 11. MARITAL STATUS 12. WAS DECEDENT	- F1455 111 1 0 4 1			21550				SA	
BY		YES 2 X			ENOENT OF NISPAI ecify Cuban, Mexica 2 NO Specif	in, Puert		or No—	Black	, White, stc.
	15. OECEOENT'S EOUCATION (Specify only highest grade completed)	(G	ive kind of wor	SUAL OCCUPATION done during mo	N st of working	. 10	Sb. KINO OF BUS	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)		NE EMP	,		- [SHO	DE FA	CTOR	Y
NO.	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First	, Middle, Malden	Sumame)		
BE (JOHN KACHUR				MARY		ozdziew			OXWX)
5	196. INFORMANT'S NAME (Type/Print) JOHN BOTTKO			NETT RO	AD		mber, City or Town KLAND,			
	20s. METHOO OF DISPOSITION 1 Burlei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)		ANO OATE OF	OISPOSITION (No	me of	1		CATION —		wn, State W. VA.
	21. SIGNATURE ON FUNERAL SERVICE LICENSEE	M00167	7		O ACCRESS OF FA			P.O.		243 MD 21550
	23. PART i. Enter the diseases, or complicatione that shock, or haart fellure. List only one ceus	caused the de	ath. Do not							Approximate
	iMMEDIATE CAUSE (Finel			E RECTU	M					interval Between Onset end Daath YEARS
_	DUE TO (OR AS A CONSEQUENCE OF):									
NOT.	if any, leading to immediate	OR AS A CONSE	DUENCE OF):							
FICA	cause, Entar UNDERLYING CAUSE (Disease or injury thet initiated eventa	OR AS A CONSE	DUENCE OF:							
CERTIFICATION	resulting in death) LAST									
AL C	PART II. Other eignificent conditions contributing to	death but not r	recuiting in	the underlying	ceuse given in	Pert i.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS
DIC							1 TYES 2			COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE	TO CALL	SE OF	DEATH Y	ES I NO					1 YES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL	. TO CAO	3L 01		ACE OF DEATH (Ch	LAAJ	one)			
rsic	EXAMINER? 1 YES 2 X NO 1 Inpetient 2	ER/Outpetient 3	DOA 4	THER: Nursing Nom	5 XResidence	8 🗆 Oti	ner (Specify)			
	27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation		28b. TIME C	Y WO	JRY AT RK? 'ES 2 NO	28d. O	EŞCRIBE HOW II	NJURY OC	CURED	
2 Accident investigation 28s PLACE OF IN HIRDY At home form street feature office.							or Rural A	oute Number,		
COMPLETED	29s. CERTIFIER (Check only one) 1 📉 CERTIFYING PNYSICIAN: To the best of the	my knowledge, de	eth occurred	at the time, date	and place, and due	time da	ause(s) end mar	nner ss stat	led,	and manner as stated
BE CC	296. SIGNATURE AND TITLE OF CENTERIER				29c. LICENSE NUI				E SIGNED	(Morith, Day, Year)
TO B	30. NAME AND ADDRESS OF PERSON WITO COMPLETED CAUSE	OF DEATH OTE	M 27) /Sma ^-	rint)	D223	36		•	11/	2/95
	C. W. FEDDE, M.D.			FOURTH	ST. 0	AKLA	AND, MD	2155	50	
	31. DATE FILED (Month, Day, Year) NOV 03 1995	S SIGNATURE	ardall							



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	Pages 1, 2, 3 should		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TS hours after death. Page 6 may be retained by the hospital or attending physician.	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 3 s	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	PORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
TO THE HOS	TO THE FUN	be filed with	IMPORTAN

							95	3	4740	
	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPA CERTII	RTMENT OF I	EALTH AND	MENTAL HYGIEN				
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			. TIME OF DEATN	
	William Reuben	Burton				November 3	AY 199	YEAR 5	1313 м	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthday,	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	, 100	a. BIRTNPL	ACE (State or Foreign	
	218 - 01 - 8743	1 🔀 M 2 🗌 F	79 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	1016	Country)	1 1	
	9a. FACILITY NAME (If not institution, give at	reet and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUN	TY OF DEA	Tand	
B	735 Carpenters Po		Po	rryville						
5	RESIDENCE OF DECEDENT			I FE	TIVVIITE		Cec	11		
DIRECTOR	10a. STATE 10b. COUNTY	1	10c. CI	TY, TOWN OR LOCA	TION			10	Dd. INSIDE CITY	
	Maryland	Cecil		Perryvil	le			1	☐ YES 2 🙀 NO	
¥.	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZ	EN OF WHA	AT COUNTRY?	
FUNERAL	735 Carpenters Po	int Road			21903		Unit	ed St	ates	
5	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 X Y	R IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes		14. RACE	- American Indian, Vhita, etc.	
ΒY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, OIVE WAR O	R DATES		2 NO Specif		- 1	Specify:	White	
		US Army -								
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of	S USUAL OCCUPATION work done during moves retired.	ON ast of working	16b. KIND OF BU	SINESS/IND	JSTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Supervi	sor of		US Gove	rnmen	t		
M	17. FATNER'S NAME (First, Middle, Last)		Ammunit	ion Test	Y	Arsena		ility		
	James Ollie Burto	ND.					(First, Middle, Malden Surname)			
BE				C ADDRESS (Street		Pearce ural Route Number, City or Town, State, Zip Code)				
5	Mary R. Burton		1							
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE			Road Perry	vvill	e MD	21903	
	1 Donation 5 Other (Specify)	wal from State	cemetary, cremetory or Principio	other place)	-					
	21. SHINATURE OF FUNERAL SERVICE LIC	ENSEE /	rricipio	22. NAME A	O ADDRESS OF FA	11/8 Perr	YVIII	e, Ma	aryland	
	DR 87	//-			o Appress of FA					
_	1 Copers 1	Nou	1	127 Sc	outh Main	n Street, 1	North	East	, MD 21901	
	23. PART I. Enter the diseases, or c shock, or heart failure. I	omplications that cau list only one cause of	sed the death. Do n each line.	not antar tha mo	da of dying, auc	ch se cerdiac or respi	iratory arre	st,	Approximsta interval Between	
ij	IMMEDIATE CAUSE (Final							Onset and Death		
	disease or condition resulting in dasth)	. Myoc	ardial Is	farction	V				minutes	
1	disease or condition a. Myocardial Infanction oue Go (OR AS A CONSEQUENCE OF):									
NO	Sequentially list conditions,									
CERTIFICATION	tif sny, leading to immediate course. Due to (or as a consequence of):									
5	CAUSE (Disease or Injury									
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST							i 1		
CE	d									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WER							ERE AUTOPSY FINDINGS		
SC	Chronic Obstrictive Pulmonary disease							MPLETION OF CAUSE		
WE							YES 2 NO			
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH Y	ES NO C	UNCERTAI	NØ				
Y S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	ATN (Check only one)						
Sic	1 TES 2 DE NO	HOSPITAL:	Outpatient 3 🗆 DOA	OTHER: 4 Nursing Norr	e 5 -Residence	6 Other (Specify)				
H	27. MANNER OF DEATN	26a. DATE OF INJUI (Month, Day, Yea			URY AT	28d. DESCRIBE NOW I	NJURY OCC	URED		
BY	1 Natural 5 Pending 2 Accident Investigation		,		rES 2 NO					
ED	3 Suicide 6 Could not be	28e. PLACE OF INJU building, etc. (S	URY — At home, farm,	street, factory, offic		26f. LOCATION (Street a City or Town, State)		or Rural Rout	e Number,	
	4 Homicide determined					, G. 10#11, G(810)				
COMPLET	29a. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	CIAN: To the best of my kr	nowledge, death occur	red at the time, data	and place, and due	to the cause(a) and man	ner sa state	d.		
W		R: On the basis of examine							nd manner as stated.	
- 1	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI					
H	Morte Moleon				D-44	41.5-4			onth, Day, Year) 12 7, 1995	
임	30. NAME AND ADDRESS OF PERSON WHO		OEATH (ITEM 27) (Typ)	e, Print)	דדיע		, ,,,		, , , , ,	

MONTE MAKOUS, MD 111 W. HIGH STREET,

31. DATE FILED (Month, Day, 1904)

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ELKTON, MD 21921

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Specify:

3. TIME OF DEATH

10d, INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

1 YES 2 X NO

WHITE

Approximsta

24b, WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 TNO

COMPLETION OF CAUSE OF DEATH?

Intervsi Between

Onset and Death

6 Horte

8. BIRTHPLACE (State or Foreign

MARYLAND

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2. DATE OF DEATH

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1. DECEOENT'S NAME (First, Middle, Last)

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4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS HOURS MAR 215-03-6240 1 🗌 M 2 📝 F 77 YRS. 1918 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3633 SHILOH ROAD DIRECTOR HAMPSTEAD RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION MARYLAND CARROLI. HAMPSTEAD permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3633 SHILOH ROAD 21074 burial-transit ours after death. Page 6 may be retained by the hospital or attending physician 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Merried 2 Merried If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: B 3 X Widowed 4 Divorced use as the ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high for ntary/Secondary (0-12) College (1-4 or 5 +) COMPL 11 RESTAURANT OWNER FOREST INN funeral director, page 5 should be detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) WARNER RUSSELL SHAUCK MARY M. SHIPLEY notified at 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3646 HOFFMAN MILL ROAD, HAMPSTEAD, MD 21074 M. PATRICK CORNELL pe 20a, METHOD OF DISPOSITION
1 💢 Burlel 2 🗋 Cremetion 3 🗀 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must VIEW MEMORIAL PARK 11/6 SYKESVILLE. MD 4 Donation 5 Other (Specify) the medical examiner 21. SIGNATURE OF FAINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FLINE FUNERAL HOME 934 S MAIN, ST, HAMPSTEAD, MD 21074 and completely filled in by the oburial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition Atherosclentic Cardivasular traumatic event, reaulting in death) executed prior to burial, CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate the attending physician Mental Hygiene prior to death certificate be cause. Enter UNDERLYING CAUSE (Disesse or injury or other OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST injury. PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY has been signed by t Dept. of Health and Aterisis shows any 1 TYES 2 TLANO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h tem HOSPITAL OTHER: 1 YES 2 THO OR ATTENDING PHYSICIAN: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Homa 5 Realdenca 6 Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO marked, 1 Natural 5 Pending М 1 YES 2 NO L DIRECTOR: After to hours after death v ВҰ 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide S COMPLETED 8 Could not be 50 4 Homicide determined item 1 🖔 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. TO THE HOSPITAL O
TO THE FUNERAL DI
DE filed within 72 ho
IMPORTANT: If ite 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 3950 MIS 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILEO (Month, Day, 1995 NUV wa davelege Rank

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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DHMH-16 Rev 1/89

1235

a. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 X NO

white

Approximate

Onset and Death

Maryland

9c. COUNTY OF DEATH

USA

20c. LOCATION - City or Town, State

Calvert

10g. CITIZEN OF WHAT COUNTRY?

Specify:

STATE REGISTRAR

John

1. DECEDENT'S NAME (First, Middle, Last)

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31. DATE FILED (Morth, Day, Year)

4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year Mar 19, 218-01-2651 1 X M 2 | F DAYS HOURS YRS. 75 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH DIRECTOR CALVERT MEMORIAL HOSPITAL Prince Frederick Pages 1, 2, RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Calvert Huntingtown permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 2441 Plum Point Road funeral director, page 5 should be detached for use as the burial-transit 20639 Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 ☐ YES 2 ☒ NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced WWII 16e. DECEDENT'S USUAL OCCUPATION 0 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Adjuster Insurance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Thomas Cranford, Sr. at Virginia Ema Rotan BE notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carol L. Cranford 9612 47th Place, College Park, MD 20740 2 20s. METHOD OF DISPOSITION
1 ☑ Burlet 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE Emmanuel Church Cem. 4 ☐ Donation 6 ☐ Other (Specify) 11/02/95 Huntingtown, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY hours after death. ullan Rausch Funeral Home, P.A. Owings, MD nding physician and completely filled in by the t Hygiene prior to burlat, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List IMMEDIATE CAUSE (Fine) the disease or condition_ DUE TO (OR AS A CONSEQUENCE OF): event, reaulting in death) the death certificate be executed within HEMISCLERUNC HEART MIEMSE traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): the attending physician Mental Hygiene prior to If any, leading to immediate MARETES IMELLITUS cause. Enter UNDERLYING other 1 CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 6 PART It. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? has been signed by 1 Dept, of Health and that LEMAL shows any MIENSE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DIRECTOR: After this certificate hours after death with the State item 28 is marked, or item HOSPITAL: OTHER: 1 YES 2 NO ER/Outpatient 3 🗆 DOA 4 - Nursing Homa 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural S Pending Investigation 1 YES 2 NO BY Accident 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide COMPLETED 6 Could not be 4 Homicide OR 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE QE CERTIFIER 29c. LICENSE NUMBER BE M44618 Whenon

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

Sv. 12 200

Daviden-Rardall

32. REGISTRAR'S SIGNATURE

Prince

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Jr.

Cranford

2. DATE OF DEATH

October 30, 1995

1920

95 34742

3. TIME OF DEATH

a

OF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 30195 DHMH-16 Rev 1/89

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

COMPLETION OF CAUSE

Silver

<u>...</u>

3. TIME OF DEATH

DHMH-16 Rev 1/89

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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OCTOBER 26,1995 10:25amm JAMES EDWARD CRENSHAW 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. August ,1910 WASHINGTON. 578-16-6565 20 D.C Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Montgomery Bethesda 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Gaithersburg 1XXYES 2 NO permit. Montgomery 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? bunial-transit 9927 Tambay Court 20879 U.S.A. retained by the hospital or attending physician. 5 should be detached for use as the bunal-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 15 Ves 2 □ NO IF YES, GIVE WITH OR DATES 8 / 7 / 43 − 11 / 5 / 43 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Ricen, stc.) 14. RACE — American Indian, Black, Whits, etc. 1 Never Merried 2 Merried 1 TES 2 NO Specify Specify: BY 3 Widowed 4 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION

(Show kind of work done during most of working ETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done iffe. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) COMPL 10th Custodian Private 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) at James Crenshaw Minnie Thompson BE funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Lewis Crenshaw Tambay Ct, Gaithersburg Md. 20879 9 20e. METHOD OF DISPOSITION

1 Substitute Sub 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 28c. LOCATION — City or Town, State must 1 Donation 5 Other (Specify) 10/31/95 Triangle, Va. Quantico Nat. Cem. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Johnson & Jenkins Inc 20011 filled in by the fi /16 Kennedy St., N.W. Wash. D.C. medical 23. PART I. Enter the dieesses, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heart failura. List only one cause on each line. interval Batween Onset and Deeth IMMEDIATE CAUSE (Finel cremation, the disease or condition resulting in death) and completely fi to burial, cremation CVG other traumatic event, DUE TO (OR AS A CONSEQUENCE OF SEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A 10 if sny, leeding to immediate cause. Enter UNDERLYING the attending physician a Mental Hygiene prior to certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 Injury, PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS 24a, WAS AN AUTOPSY MEDICAL s been signed by the PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TES 2 NO Shows COPP 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | PHYSICIAN: s certificate has be th the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one, HOSPITAL:
1 | Inputient 2 | ER/Outpetient OTHER: 4 | Mursing Home \$ | Residence 8 | Other (Specify) also resulted o 1 YES 2 NO PHYSICIAN: 0 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCUBED 28c. HEADRY AT this c is marked, 14 Natural 5 Pending investigation IND THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death wi IMPORTANT: If Item 28 Is marke YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home in building, etc. (Specify) 3 Suicide 6 Could not be COMPLETED 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. (Check only one) ation end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated 29c. LICENSE NUMBER BE 126 D03518 2 O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9410 Old Georgetown Rd., Bethesda Md. 20814 Elliot Goldstein .D.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
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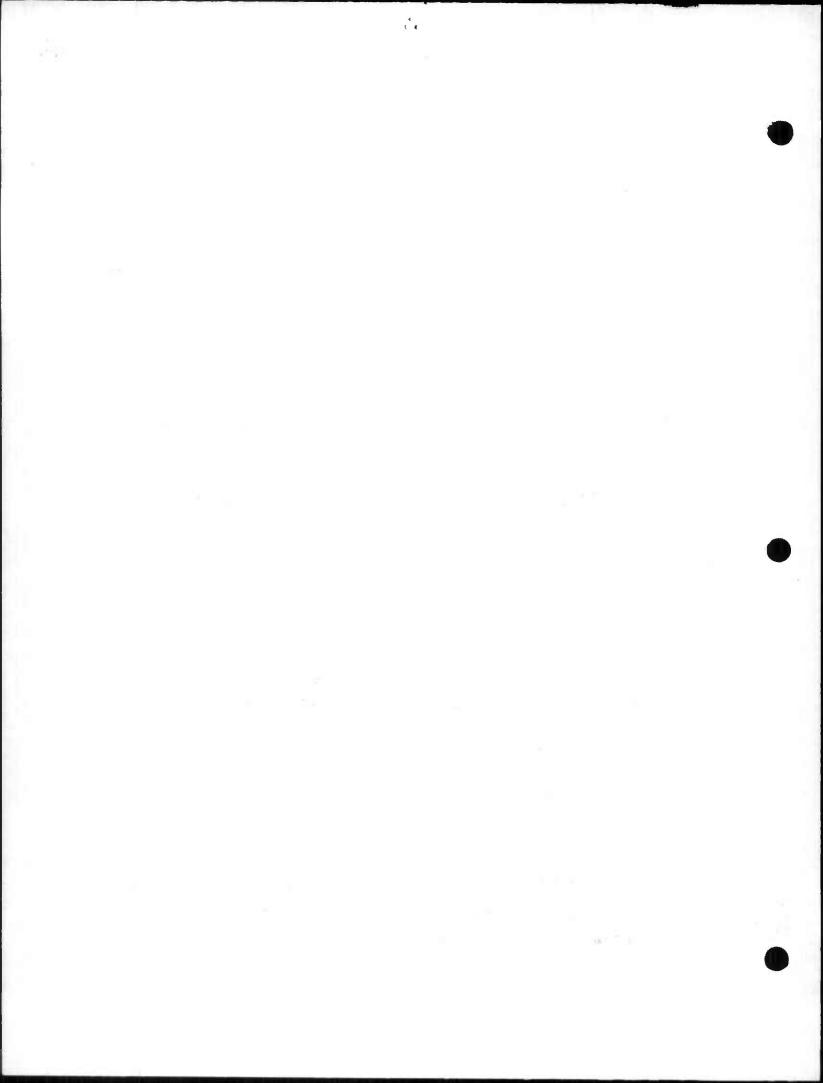
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

•	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTAL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)	ry V. Collins	*			2. DATE OF DEATH MONTH DATE OF DEATH DATE OF DATE	Y YE	3. TIME OF DEATN 2:20P M
	4. SOCIAL SECURITY NUMBER		rrs. last birthday)tt	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH Sept. 27,1	8.	BIRTHPLACE (State or Foreign Country) ashington, D.C.
R	9a. FACILITY NAME (If not institution, give str Physicians Memo	·			R LOCATION OF DE		9c. COUNTY	OF DEATH
6	RESIDENCE OF DECEDENT						01101	
DIRECTOR		rles	10c, CITY, 1	Wald	lorf			10d. INSIDE CITY LIMITS? 1 YES 2 1 NO
FUNERAL	100. STREET AND NUMBER 2656 Hunt Place	#104			20602			U.S.A.
B	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 TYES IF YES, GIVE WAR OR DATE	2 ANO	ff yes, spe		IIC ORIGIN? (Specify Yea n, Puerto Ricen, etc.)	or No— 14.	RACE — American Indian, Black, White, atc. Specify: White
COMPLETED	15. DECEDENT'S EOUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	Ba, DECEDENT'S US (Give kind of worn life, Do NOT use n Homemak	k done during mot etired.)	N st of working	166, KIND OF BUS		TRY
COM	17. FATHER'S NAME (First, Middle, Last) Theodore Randall					ME (First, Middle, Maiden V. Ogle	Surname)	
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AS	DDRESS (Street a		Route Number, City or Tow	n, State, Zip Co	de)
오	Lois McGowan		3677 R	led Bud	Ct., Wal	ldorf, Md.		
	20e. METNOD OF DISPOSITION 1 \(\Delta \) Burlet 2 \(\Delta \) Cremation 3 \(\Delta \) Hamo 4 \(\Delta \) Donetion 4 \(\Delta \) Coher (Specify)	wal from State 20b.Pf	LACE AND DATE OF	DISPOSITION (Na T PICE DE TE	ery 10/	730/95 Su		or Town, State , Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	O Kal	J	Georg		las Funera		, Md,20745
	IMMEDIATE CAUSE (Final	omplications that ceused to clat only one cause on each a. ATHERO S DUE TO (OR AS A C	CLERO				,	Approximate Interval Between Onset and Daeth
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):							
PHYSICIAN: MEDICAL C	PART II. Other eignificant conditions PIABETES HEART FA DID TOBACCO USE CONTR	, RENA	L FA NTEST	ILUF	OBSTRUC	PERFOI 1 YES 2	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	, PLACE OF DEATN	(Check only one)				
14SI	1 TYES 2 NO 27. MANNER OF DEATN	1 Nonpatient 2 ER/Outpat	lent 3 DOA 4	☐ Nursing Hom		8 Other (Specify) 28d. DESCRIBE HOW	NULTRY OCCUR	PFD
	1 Netural 5 Pending	(Month, Day, Year)	INJUF	RY WO	PRK?	200. DESCRIBE NOW	110011 00001	The
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At home, farm, attread building, atc. (Specify)							Rural Route Number,
COMPLET	anni Correct Orally	CIAN: To the best of my knowled R: On the basis of examination s						
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	ngantle	4		29c. LICENSE NUI	064		IGNED (Month, Day, Year) 0 - 27 - 95
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEAT			52601		EACH, Md	RD 20622
	31. DATE FILED (Mooth Day, Year) 1995	32. APGISTRAMS SIGNAT	or Rardall					-





U. JEFFEN FOE

31. DATE FILED (Morth, De), 1601)

14. OCT 3 0 1995

DIVISION OF	TO THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this ce be filed within 72 hours after death with the	IMPORTANT: If Item 28 is marked,
(8)	-	Va	ì

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	FOR 1 - STATE	STATE OF N			TMENT OF	HEALTH AND				
1	1. DECEDENT'S NAME (First, Middle, Last			ERITE	ICATE OF	DEATH	2. DATE OF MONTH	DAY	YEAR 995	3. TIME OF DEATH 7:45 P
7.5 12	WILLIAM 4. SOCIAL SECURITY NUMBER	ALBERT 5. SEX 1 M 2 D F	8. AGE (In yrs. les		IF UNDER 1 YEAR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D	BIRTH ay, Year)	8. BIRTI	HPLACE (State or Foreign ry)
	9s. FACILITY NAME (If not institution, give	street end number)	01	110.		OR LOCATION OF	DEATH	9c. CO	UNTY OF C	
L DIRECTOR	6701 COLMON S RESIDENCE OF DECEDENT 19a, STATE 19b, COUN	treet		10c CIT	Y. TOWN OR LOCA	tol Hei	gnts	PLI	nce	George's
	-	nce Geoi	ge's	C	-	Height	s			LIMITS?
FUNERAL	100. STREET AND NUMBER 6701 Calmon	Street			1	20743			.S.A	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 1 Never Merried 2 Merried 3 Widowed 4 Divorced		TEVER IN U.S. AR YES 2 N WAR OR DATES TO 19	NO	If yes, s	CENDENT OF HISP. pecify Cuben, Mexics \$ 2 10 NO Specific	can, Puerto Ric	Specify Yes or No-	14. RAC	E — American Indian, k, White, etc.
COMPLETED	15. DECEDENT'S EC (Specify only highest gra-	UCATION	16a, DE (G life,	ive kind of Do NOT u		nost of working		Federal	Ga	kernment
OM	12th Motor Vehicle Operator 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First)					NAME (First, Mid				
BE	Joseph T. Cook Joella McKoy									
2	Juanita Johnson/Sister 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Calmon St, Capitol Heights, MD 2074								MD 20743	
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremition 3 Re 4 Donation 8 Ofter (Specify) 21. SIGNATURE OF FUNERAL SERVICE		Mary Mary	ematory or o	<u>d Vete</u>			20c. LOCATION		
	1 Jour	13 16	no	_	J.B	. JENKI	NS FU	NERAL H		r, MD 207
	23. PART F. Enter the disease, o ahock, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. BRONC		capu	J.B 7474 not enter the m	JENKI Lando	NS FU ver R	d, Land	love	Approximate interval Between
RTIFICATION	ahock, or heart failure IMMEDIATE CAUSE (Final disease or condition	a. BRONG DUE TO b. DUE TO	HOGENIC	EQUENCE O	J.B 7474 not enter the m	JENKI Lando	NS FU ver R	d, Land	love	Approximate interval Between
SICAL CE	shock, or heart failure immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. BRONG DUE TO b. DUE TO c. OUE TO	O (OR AS A CONSE	EQUENCE O	J.B 7474 not enter the m NONA PFI:	JENKI Lando Lando Lando Lando Lando	NS FU Ver R uch ea cardla	d, Land	ovel	Approximate interval Betwee Onset and Deat
MEDICAL	shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditi	a. BLEIN DUE TO DUE TO OUE TO	O (OR AS A CONSE	EQUENCE O	J · B 7474 not enter the m NOWA FF: OFF: In the underlyi ES □ NO	JENKI Lando	NS FU Ver R uch ea cardla	d, Land c or respiratory of	ovel	Approximate interval Betwee Onset and Dea
MEDICAL	ahock, or heart failure immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daath) LAST	b. DUE TO c. OUE TO d. ONE CONTRIBUTE TO CA	O (OR AS A CONSE	EQUENCE OF DEA	J.B 7474 not enter the m NONA OF): In the underlyl INTH (Check only on TOTHER:	JENKI Lando	NS FU Ver R uch ea cardia	d, Land c or respiratory of	ovel	Approximate interval Betwee Onset and Deal Onset an
IYSICIAN: MEDICAL	ahock, or heart failure immediate cause. Enter UnDERLYING CAUSE (Disease or injury that initiated events resulting in death) DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Naturel 5 Pending	a. BLEIN ONE TO DUE TO DUE TO C. OUE TO d. One contributing to HOSPITAL: 1 Inpatient 2 28e. DATE O (Month, 1)	O (OR AS A CONSE	EQUENCE OF DEATH YILL CE OF DEATH 3 DOA 28b. Till 22bb.	J · B 7474 not enter the m I NONA IF: In the underlyl INTH (Check only on OTHER: 4 Nursing He ME OF 28c. II JUNY J · B J	JENKI Lando	In Part I. 2	d, Land c or respiratory of	ove:	Approximate interval Betwee Onset and Deat on Deat On
D BY PHYSICIAN: MEDICAL	ahock, or heart failure immediate cause cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other significant conditions and in the conditions of the conditions of the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other significant conditions of the conditio	a. BLANCE B. DUE TO DUE TO C. OUE TO d. Ona contributing to ITRIBUTE TO CA HOSPITAL: 1 Inpatient 2 28e. DATE O (Month, Inc.) 28e. PLACE building	O (OR AS A CONSE	EQUENCE COLUMN TO THE PROPERTY OF THE PROPERTY	J · B 7474 not enter the m I NOWA IF: OF: In the underly! ATH (Check only on OTHER: 4 Nursing Ho ME OF JURY M 1	JENKI Lando	In Part I. 2 AIN 2 28d. DESC	d, Land c or respiratory of 4a. WAS AN AUTOPS PERFORMED? YES 2 NO	OVE 1	Approximate interval Between Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Death?
D BY PHYSICIAN: MEDICAL CERTIFICATION	ahock, or heart failure immediate cause condition resulting in death) Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditions	a. BLAIN ONE TO DUE TO	O (OR AS A CONSE O (OR AS A C	COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF DEATH IN COUENCE OF DEATH IN COUENCE OF DEATH IN COUENCE OF THE COUENCE OF	J · B 7474 not enter the m 1 Now A F): In the underlyl In the underlyl ATH (Check only on OTHER: 4 Nursing He ME OF JURY M 1 street, factory, of	JENKI Lando	In Part I. 2 AIN 2 286. Description of the cause	d, Land c or respiratory of 4s. WAS AN AUTOPS PERFORMED? YES 2 V NO Specify) RIBE HOW INJURY of ON (Street and Num Town, Stele)	OVE) Prreat, Y 24	Approximate interval Betwee Onset and Deal Onset an

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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JEGD WALTER MED HOSPITAL

WASHINGIN DL 20307-500

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retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 the funeral director, page 5 should Page 6 may be

be detached for use as the burial-transit

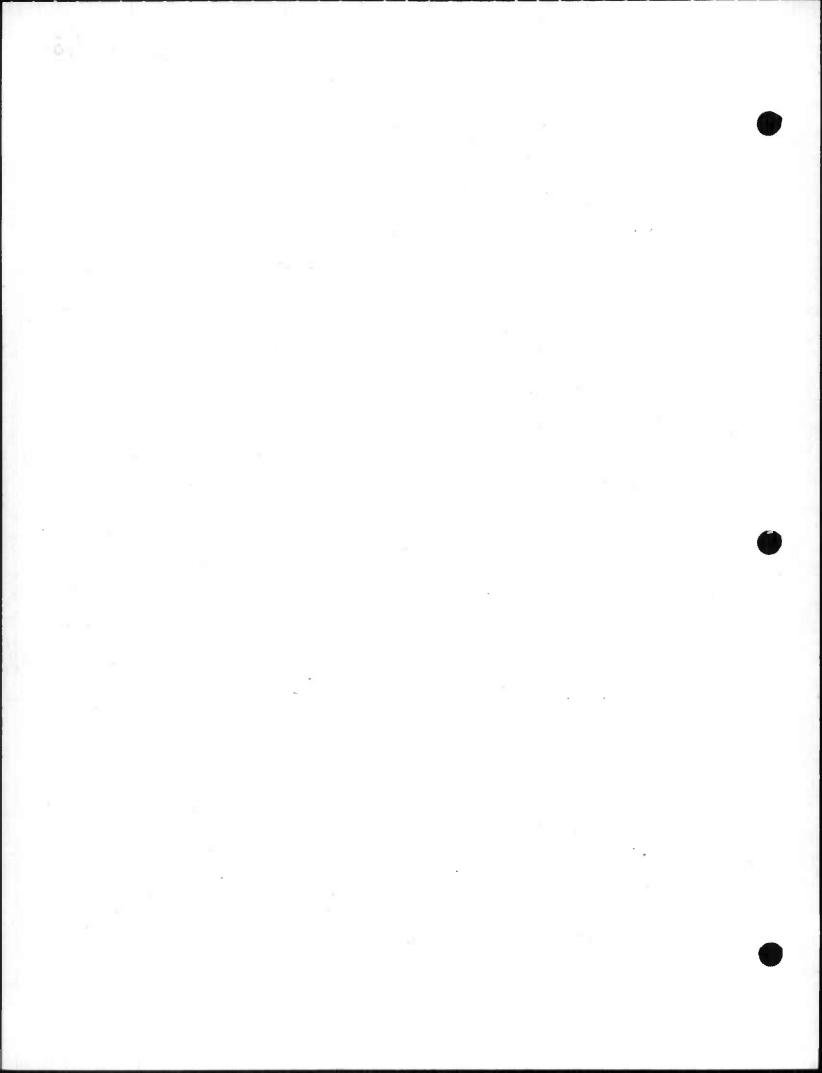
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permit. Pages 1, 2, 3 should

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8	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exami
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	HYSII	this ce	WITH	ked,
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Jeremiah Clubb 1995 October 31 8:25A A SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) May 28 1923 5. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 577 28 4110 1 🛣 M 2 🗌 F 72 Washington D.C 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Doctors' Community Hospital Lanham Prince George's RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George's Maryland Bowie XX YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12836 Holiday Lane 20715 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ... YES 2 NO IF YES, GIVE WAN OR DATES RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced WWII White No COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Security Guard Security once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ BE Harry Randolph Clubb Henora Driscoll notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jeffrey Clubb 14510 Picket Oaks Rd. Centreville Virginia 22020 9 20a. METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 Donation 8 Other (Specify) Maryland Veterans Cemetery 11/3/95 Crownsville Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY obert Robert E. Evans Funeral Home, P.A. lans 100 16000 Annapolis Rd. Bowie Md. 20715 medical 23. PART I. Enter the diseases, or complications that caused the dasth. Do not anter the mode of dying, such as carding or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Peath the Stive disesse or condition one INKS resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): openan CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury other S.A CONSEQUENCE OF thet initisted events eumon10 resulting in death) LAST 9 PART II. Other algnificant conditions contributing to geath but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? any 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN 17 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL: OTHER: 1 | YES 2 | NO 1. Inpatient 2 ER/Outpatient 3 DOA Home 5 ☐ Residence 8 ☐ Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural M 1 YES 2 NO В 2 Accident 26e. PLACE OF INJURY. At home, farm, atreet, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 8 Could not be 4 | Homicide 200

29s. CERTIFIER (Check only one) DICAL EXAMINER: On the 29c. LICENSE NUMBER 8 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT (ITEM 27) (Type, Print) GISTRAR'S SIGNATURS NOV 01 1995



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TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be sind with the State Dent, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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FOR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H	YGIENE
REGISTRAR	CERTIFICATE OF DEATH R	EG. NO.

	1 - STATE REGISTRAR	SIAIE UF IV	CE	RTIF	ICATE	OF I	DEA	TH	MENIAL	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH	
	HELEN	VIRGIN	IA c	COWS	CTD				OCTOR	BER 3		995	4:30 P M	
	4. SOCIAL SECURITY NUMBER	5. SEX	birthday)	IF UNDER	1 YEAR	IF UNDER	UNDER 24 HRS. 7. DATE OF BIF			OF BIRTH 8.		LACE (State or Foreign		
	228-72-0487	1 M 200 F	50	YRS.	MONTHS	DAYS	HOURS	MIN.	May 7	ey, Year)	5	Nort	h Carolina	
	9a. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY,	TOWN OR	LOCATI	ON OF D				NTY OF DE		
DIRECTOR	2402 Virginia Ave	enue			Lan	idove	er				Pri	nce G	eorge's	
EC	10e. STATE 10b. COUNTY		10c, CIT	Y, TOWN O	R LOCATIO	ON						10d. INSIDE CITY		
8	MD Prince	s	Та	ndove	r							YES 2 NO		
A	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?												HAT COUNTRY?	
FUNERAL	2402 Virginia Ave	niio					2	0785	;	- 4		7		
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARM				NDENT (OF HISPA	NIC ORIGIN? (or No-	14. RACE -	American Indian, White, atc.	
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced		FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			If yee, specify Cuben, Maxican, Puert 1 YES 2 NO Specify:						Specify		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DEC	EDENT'S	USUAL OC	CUPATION	N t of world	ina	16b. KI	ND OF BUSI	NESS/IN(DUSTRY	TO COLOR	
ᄪ	Elementary/Secondary (0-12)	College (1-4 or 5 +	- Alfa	Do NOT u	se retired.)	rork done during most of working e retired.)							11/60	
MP	8th		Ho	ouse	wife				N/A					
8	17. FATHER'S NAME (First, Middle, Last)								AME (First, Mide		urname)		- 100	
BE	Matthew Wiggins								ne War					
2	19a. INFORMANT'S NAME (Type/Print)	FIANCE							Route Number,				-200	
	Raymond Bennett /	TIMOL	20b, PLACE A					. La	ndover			City or Tow	o State	
	1) Buriel 2 Cremetion 3 Remo	ovel from State	cemetery, cren	netory or	other place)				10/3				n, Suita	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	Harmor	IV M		NAME AND			ACILITY	Land	love:	r,MD		
	+ 1 11 aware	81	Brayt	m					S FUNE RD. L			MD :	20785	
	23. PART I. Enter the diseases, or o												Approximate	
	shock, or heart fellure.	List only one ceu	ise on eech line.										Interval Batween Onset and Death	
	IMMEDIATE CAUSE (Finel disease or condition	Laru	ngeal	(0	incer								2 years	
	resulting in death)	DUE TO	OR AS A CONSEC	UENCE (DF):								1 3	
z	Sequentially list conditions b.													
음	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
SA	CAUSE (Disease or Injury													
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
CERTIFICATION	d													
N C	PART II. Other significent condition	e contributing to	death but not re	eauiting	In the un	derlying	ceuse	given li	n Part I. 2	4a. WAS AN A			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
ICAL									1	YES 2			COMPLETION OF CAUSE OF GEATH?	
MED													1 YES 2 NO	
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
ZIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF OE	ATH (Check									
SIG	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		5 M.F	tasidence	8 🗆 Other (S	Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF (Month, D		28b. TI	ME OF	28c. INJU	JRY AT		28d. DESC	RIBE HOW IN	JURY OC	CCURED		
ВУ	1 V Natural 5 Pending 2 Accident Investigation				М	1 🗌 Y	ES 2	□ NO						
	3 Suicide 8 Could not be		of INJURY — At hor etc. (Specify)	me, farm,	street, fact	ory, office				ILLOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	4 Nomicide determined													
PL	Check only	CIAN: To the best of	my knowledge, de	ath occur	rred at the ti	lme, data	and plac	e, and du	e to the cause	e(s) and man	ner aa str	ated.		
O	one) 2 MEDICAL EXAMINE	R: On the basis of a	xamination and/or i	investigat	lon, in my o	pinion, de	eath occ	ured at th	ne time, data ar	nd place, and	I due to t	the cause(s)	and menner as stated.	
ш	296. SIGNATURE AND TITLE OF CERTIFIES		11 15	-1			29c. LIC	CENSE N	MBER	,	29d. DA	TE SIGNED	(Month, Day, Year)	
TO B	Jan Muster		ttending		1	an	20	542	2 (D.	c.)	•	10/	31/95	
F	JOSEPH P. Car	1 1	SE OF DEATH (ITE	,	De, Print)	11/19	St.	N. U	U.; W	ashiv	as to	A .	e. 20010	
	31. DATE FILED (Month, Day, Year) NOV 02 1995		AUCULAT A			1			, , ,		3.00	-, -		
	1404 0 - 1999	1		-										



Via.

		1 - STATE REGISTRAR	STATE OF N	MARYLAND)	/ DEPAI	RTMENT	OF H	DEAT	AND M	ENTAL HYGIEN REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)	-						2. DATE OF DEATH		3. TIME OF DEATH
		Agnes	CORTE			-				October 2	8 19	95 0730 AM M
		4. SOCIAL SECURITY NUMBER 213-40-8426	5. SEX	6. AGE (In yrs. 76	last birthday) YRS.	MONTHS	1 YEAR DAYS	IF UNDER	88464	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
3 should		9e. FACILITY NAME (If not institution, give			1110.	9b. CITY	TOWN	OR LOCATE	ON OF DEAT			9 Maryland
2, 3 st	СТОВ	Doctor's Communi		a1		Lanl						ce George's
Pages 1, 2	ECT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY		10c CI	Y, TOWN C	DR LOCAT	ION				10d. INSIDE CITY
. Pag	DIRE	Maryland Prin	ce George	t _s	100.01			Cit	У			LIMITS?
nsit permit.	3AL	100. STREET AND NUMBER 4142 Bunker Hill	Road #31	6			101	ZIP CODE	722			EN OF WHAT COUNTRY? S.A.
1215-0020 or attending physician, r use as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	ARMED		f yes, sp	ecify Cube	OF HISPANIC in, Mexicen, Specify:	ORIGIN? (Specify Yes Puerto Ricen, atc.)	or No— 1	14. RACE — American Indian, Black, White, etc. Specify: White
Se at Se	9	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	16a. I	DECEDENT'S (Give kind of	USUAL O	CCUPATIO	ON et of workin	20	16b. KIND OF BUS	SINESS/INDU	STRY
ed fo	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +		life. Do NOT u	emake		SI OF WORK		Own H	ome	
YLA by the be det	BE COI	17. FATHER'S NAME (First, Middle, Last) Joseph Pruss							Ţ	(First, Middle, Maiden Jnavailab	le	
	2	19e. INFORMANT'S NAME (Type/Print) Maria Cortez		1	196. MAILING	ADDRESS Vindh	(Street a am L	ane,	or Aural Aou Silv	rte Number, City or Tow er Spring	n, State, Zip C	20902
e 6 m rector.		20e, METHOD OF DISPOSITION 1		20b.PLAC cemetery, of Metre	cremetory of o	of bispos ther place tan	rema	meol atory	11/0	1/95 Ale:	cation – ci Kandri	ity or Town, State ia, Virginia
ALT death. funera		21. SIGNATURE OF FUNERAL SERVICE L	Jerson			Fr 47	anc:	is Ga Balti	imore	S Sons Fur Ave., Hy	attsvi	Home, P.A. ille, MD 20781
hours after ed in by the or removal		23. PART i. Entar the diseasas, or shock, or heart fellure	complications that List only one cau	t caused tha dise on each ile	daeth. Do	not anter	tha mo	de of dyi	ing, such i	ns cardiac or reapi	retory arres	st, Approximate interval Between
y fill the		iMMEDIATE CAUSE (Final disease or condition resulting in death)	. Kesp	raton	y f	usu.	Ha	enc	1			Onset and Death Gudden Guddey Tosc Thought
ecuted within nd completel burial, crema	2		Lezn	OR AS A COM	A)	mil s	VI					Gudden.
K 5 COE	TIO	Sequentially list conditions, if any, leeding to immediate	17	(OR AS A COMB	DUENCE O	F):	- 00					12000
ficate be physicial prior le prior le prior	2	cause. Enter UNDERLYING CAUSE (Disease or injury		OM AS A CONS	EQUENCE O	5 .						TUSIC
death certificate attending physic ental Hygiene ph	CERTIFICATION	thet initiated events resulting in death) LAST	a Longe	the f	ral	- G	zilu	ue				Triouts
1 4 E	CAL	PART II. Other significent condition		deeth but not	t resulting	in tha un	derlying	ceuse g	given in Pa	ert i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS
any and the	MEDIC	Jenena	Huseon							1 TYES 2	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
law requires as been sign Dept. of Heal 23 shows		DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DE	ATH Y	S 🔲 I	10 🗆	UNC	ERTAIN	X		1 TYES 2 M NO
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF DEA							
of the state of	IXSI	1 TYES 2 NO	1 Inpatient 2	ER/Outpatient		-	Ing Home			Other (Specify)		
NG PHYSII fler this ce eath with t	Y PHY	1 Natural 5 Pending	' 26e. DATE OF (Month, De		28b, TIM	IE OF JURY M		URY AT RK? 'ES 2		8d. DEŞCRIBE HOW II	NJURY OCCU	RED .
) D V D W	red BY	2 Desident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF	F INJURY — At I etc. (Specify)	home, term,	street, fact				61. LOCATION (Street & City or Town, State)	and Number or	: Rural Route Number,
DIAN DIAN	LET	290. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of	my knowledge.	death occurr	ed at the H	me date	and place	and due to	the cause(s) and man	nor on stated	
国政政员	COMPL											ceuse(s) and menner as stated,
THE HOSP! THE FUNEF filled within	ш	296. SGNATURE AND TITLE OF CERTIFIC	ER					29c. LICE	NSE NUMBE	R	29d. DATE S	SIGNED (Month, Day, Year)
E E E E	TO B	Myga.	145					1)-	-55	252	10	13005
5)		30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	SE OF DEATH (IT	20) Type	Λ	Ne	# 2	220	Situer	Spor	P/20002
		NOV 02 199	32. REGISTRA	H'S SIGNATURE	ardall						1	

88.7

ospital or attending physician. hed for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

TO BE COMP	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
al examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached oval.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
fter death. Page 6 may be retained by the hospi	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within announce after death. Page 6 may be retained by the hospi
DAL! IMURE, MARTLAND	CHARLES OF ALL AL RECORDS, P.O. BOX 601 601

	1 - STATE REGISTRAR	STATE OF MARYLAN		MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN											
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH									
	Edith Louise	Cantville					5:00 P M									
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH Month Day Year Country															
			-20 -2 30002 CIII	10/23/20 MD												
α	99. FACILITY NAME (If not institution, give street and number) #17 Riverview Mobile Park Bishopville 9c. COUNTY OF DEATH Worceste															
DIRECTOR	RESIDENCE OF DECEDENT	WOOTIC TATK		Distiopvine		WOI	cester									
RE	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY LIMITS?									
		cester		Bishopville			1 TYES 2 NO									
3AL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF WHAT CO										
FUNERAL	#17 Riverview M			21813			USA									
F	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN U. FORCES? 1 YES	2 X NO	13. WAS DECENDENT OF HISP If yee, specify Cuben, Maxi	ANIC ORIGIN? (Specify Ye can, Puerto Ricen, etc.)	s or No — 14.	RACE — American Indian, Black, White, etc.									
В	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	S	1 YES 2 XNO Spec	olfy:		Specify: white									
G	15. DECEDENT'S EDUCA	TION 16	ia. DECEDENT'S U	SUAL OCCUPATION	16b. KIND OF BU	SINESS/INDUS	TRY									
H	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of wor	rk done during most of working retired.)												
AP.	11		Office	Clerk	Insu	rance										
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				IAME (First, Middle, Maiden											
Ethan Allen Moody Edna Ruth Kaline																
2	19a, INFORMANT'S NAME (Type/Print)	211		DDRESS (Street and Number or Rure												
П	Thomas F. Cantv			Donnegal Way												
	1 XBurtel 2 Cremation 3 Remov	al from State 20b.PL	ACE AND DATE OF ry, cremetory or othe	oisposition (Neme of ge Cemetery	DATE 20c. LO	CATION — City	or Town, State									
	21. SIGNATURE OF TWEERAL SERVICE LICES	NSEE Dr	ula Kla	22. NAME AND ADDRESS OF	11/3/95 Ba	Itimore	, MD									
	MA Million	2			Burbag		eral Home									
-	11.7x11/c	thelay_		108 Williams			21811									
	23. PART is Enter the discesses Dr cDi shock, or heart fellure. Li	mplicetions that caused the st Dnly one cause on each	ne death. Do no n line.	l enter the mode of dying, su	ich as cardiac or reap	iratory arrest	Approximate interval Between									
	IMMEDIATE CAUSE (Finel disease or condition	Miner	111-1	· Se 1:			Onset and Deeth									
	resulting in deeth) e.	BUE TO (OR AS A CO	ONSEQUENCE OF:	According												
- 1		Dine	O d d	124 114												
_	I _	Sequentielly list conditions, If env. leeding to immediate DUE TO OR AS A CONSEQUENCE OF):														
NOI		DUE TO JOH AS A CO	MIRIOUENCE OF):			cause. Enter UNDERLYING										
CATION	If eny, leeding to immediate cause. Enter UNDERLYING	DUE TO SOM AS A CO	MINIOUENCE OF):													
rification	If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	,													
ERTIFICATION	If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		,													
L CERTIFICATION	If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):	the underlying ceuse given i	n Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS									
AL	If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):	the underlying ceuse given I	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE									
AL	If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):	the underlying ceuse given i		RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
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ED BY PHYSICIAN: MEDICAL	If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined	DUE TO (OR AS A CO contributing to death but BUTE TO CAUSE OF 26. HOSPITAL: inpatient 2 ER/Outpatia 28e. DATE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY - building, atc. (Specify)	DEATH YES PLACE OF DEATH 1 DOA 4 28b. TIME (INJUE) At home, farm, street	Check only one) OTHER: Nursing Home 5 Rasidence OFF 28c. INJURY AT WORK? 1 YES 2 NO set, fectory, office	PERFOI 1 YES : 1 YES : Other (Specify) 28d. DESCRIBE HOW I 28t. LOCATION (Street City or Town, State)	NJURY OCCUR	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO									
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is co	Ath the Stat	IPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DR ATTEND	ERAL DIRECTOR: After	be filed within 72 hours after death w	T. It item 28 is ma
TO THE HOSPITAL	TO THE FUN	be filed with	IMPORTAN

								9	5	34130		
	FOR STATE 0	F MARYLAN	D / DEPAR	RTMENT I	OF HE	FALTH AND	MENTAL HYGIEN	IF				
	1 - REGISTRAR		CERTIF				REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH		
	Dantord nm	n	ann	1			Oct. 24,	AY 1995	YEAR	3:00 A M		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In y	rs. last birthday)	IF UNDER 1 Y	YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1777	8. BIRTH	IPLACE (State or Foreign		
	216-14-2247 1XM2	F 82	YRS.	MONTHS	DAYS	HOURS MIN.	Mar. 18, 191	13	Chas	tertown MD		
	9s. FACILITY NAME (If not institution, give street and number,		9b. CITY, TI	OWN OR	LOCATION OF E		7	UNTY OF D				
H	Chestertown Rehabilitat:	-02	Ch	oato	ertown							
DIRECTOR	RESIDENCE OF DECEDENT	CL	I GIR	ESTE	EL LOWII	-		nt				
R	10a. STATE 10b. COUNTY	Y, TOWN OR					10d. INSIDE CITY LIMITS?					
	Maryland Kent			Cheste	erto	own				1 YES 2 XNO		
AL	10e. STREET AND NUMBER				10f. 2	ZIP CODE		10g. CI	TIZEN OF W	VHAT COUNTRY?		
EH	229 Queen Street					21620			USA			
FUNERAL		DENT EVER IN U.	S. ARMED	13. WA	S DECE	NDENT OF HISPA	NIC ORIGIN? (Specify Yes	s or No—	14. RACE	- American Indian,		
	IF YES GIV	1 YES 2	s X∃NO			olfy Cuban, Maxic	an, Puarto Rican, atc.)		Speci	white, etc.		
ВУ	3√3 Widowed 4 □ Divorced									DIACK		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18	a. DECEDENT'S	work done duri	UPATION	of working	18b. KIND OF BU	SINESS/IN	DUSTRY			
Щ	Elementary/Secondary (0-12) College (1-4 or 5+)											
MP	4th	Mainte	nance	Wor	ker	Washi	ngto	n Col	llege			
\bar{g}	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden	.,					
	Estella Johnson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
70									ip Code)			
F	William D. Cann Sr.		P.O.	182, V	Vort	on, Mar	ryland 21678					
	20s. METHOD OF DISPOSITION 1/2 Burlel 2 Cramation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Complete or complete											
	4 Donation 5 Other (Specify)	Gemeter Mt.	Pleas	ant Ch	nurc	h Cem.	10/28/95	Fair	lee M	1D		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1		22. NA	ME AND	ADDRESS OF F	ACILITY		100 1	10		
	1 /2 //2	/_					uneral Hom	e				
	23. PART I. Enter the diseeses, or complications	Abat saverdab	t at P	But	Ler	town, [laryland					
	ehock, pr heart fellure. List pnly pne	cause on each	iine.	iot enter th	e mode	e or aying, euc	on as cerdied or reep	iretory e	rrest,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	1 (Onset and Death		
	resulting in deeth) a. FC	nal ta	ilure									
	DUE	TO (OR AS A CO	NSEDUENCE O	F):								
8	Sequentially list conditions, b.	TO (OR AS A CO	MACOUEMOE O									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	TO (OH AS A CO	M SEDUENCE O	r):								
일	CAUSE (Disease or injury	TO (DR AS A CO	NSEODENCE O	F)+								
Ē	resulting in death) LAST	10 (51) 75 7 50	NOEGOENOE O	· /-						j l		
B	d											
7	PART II. Other eignificant conditions contributing	to deeth but r	not resulting	In the unde	rlying	cause given in			24b.	WERE AUTOPSY FINDINGS		
5	acteriosclerotico	eact	liseas	se.			PERFOR	_		AVAILABLE PRIOR TO COMPLETION DF CAUSE		
MEDICAL	congestive heart	Failur					1 1 7E3 4	EPHO.		OF DEATH?		
	DID TOBACCO USE CONTRIBUTE TO			S 🗆 NO	<u>. П</u>	UNCERTAI	N D			1 TYES 2 THO		
NA I	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT			UNCERIAL	N L J					
PHYSICIAN:	EXAMINER? 1 UPS NO 1 Inpatient			OTHER			WE SER STREET					
¥		OF INJURY	28b. TIM		g Home Sc. INJUR		8 Other (Specify) 28d. DE\$CRIBE HOW I	N IIIDV OC	CUBED			
	1 Natural 5 Pending (Mont	h, Day, Year)		URY	WORK		280. DESCRIBE HOW I	NJUHT OC	CORED			
B	2 Accident Investigation 28s. PLAC	E OF INJURY -	At home form			2 110	201 LOCATION (Street		C (C	to the North		
	3 Suicide 8 Could not be 4 Homicide datarmined	ing, atc. (Specify)			,		281. LOCATION (Street a City or Town, State)	eru Numbe	or numii H	oute Number,		
	29a. CERTIFIER							-	_			
MP	(Check only The CERTIFTING PHYSICIAN: To the bes											
COMPLETED	2 MEDICAL EXAMINER: On the basis	or examination an	d/or Investigatio	n, in my opin	ion, des	nth occured at the	time, data and placa, an	d due to t	ha cause(a)	and manner as stated.		
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	hald m			2	29c. LICENSE NU		29d, DA	TE SIGNED	(Month, Day, Year)		
0 8	m Brons	ngoun M	0			0333	14	•	10-2	5-95		

Chestertown, Md. 21620

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Bieenfeld, M.D, 100 Brown St.

31. DATE FILED (Month, Day, Year)

OOT 26 1995

32. REGISTRAR'S SIGNATURE
Julia Dauden Randall

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

Charles C	ARROLL	Cal	Llahan		2. DATE O		95 ^{YEAR}	3. TIME OF DEATH 9:24 PN
	5. SEX 6. AGE 6. AGE 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF (Month, JUNE)	F BIRTH Day, Year) 16,192	8. BIRTI- Countr 7 MA	PLACE (State or Foreign ry) RYLAND
MEMORIAL HOSPIT				OR LOCATION OF	DEATH	9c. CC	TAL	
0e. STATE 10b. COUNTY	EEN ANNE'		QUEEN	STOWN				10d. INSIDE CITY LIMITS? 1 YES 2X NO
00. STREET AND NUMBER 818 DEL RHODES	AVENUE			10f. ZIP CODE 21658		10g. 0	USA	WHAT COUNTRY?
1. MARITAL STATUS Never Merried 2 X Merried Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 XNO	If yes,	ECENDENT OF HISP specify Cuben, Mexi ES 2 NO Spec	cen, Puerto Ri	(Specify Yes or No- cen, atc.)	- 14. RACI Black Spec	E — American Indian, k, White, etc.
15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		life. Do NOT us	rork done during i	most of working		AUTOMOT		
7. FATHER'S NAME (First, Middle, Lest)			TEOMA	1		ddle, Malden Surname		
GEORGE CARROLL 90. INFORMANT'S NAME (Type/Print)	CALLAHAN		APPRECE (Comp.			NNAMON or, City or Town, State.	7/o Codel	
FRANCES P. CAL 200. METHOD OF DISPOSITION What Disposition 3 Remove 1 Donetton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	ral from State	818 b. PLACE AND DATE Conterery, cremetory or of OODLAWN	of disposition (ther place) MEMOI	Neme of	OATE	20c. LOCATION	— City or To	
iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	P):	lve	bis	2002		Onnet and Deat
PART II. Other algnificant conditions						24s. WAS AN AUTOP: PERFORMED? 1 YES 2 NO	~ T	b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH? 1 YES 2 NO
DID TODACCO LICE CONTROL	IBUTE TO CAUSE (28. PLACE OF DEAT			AIN Z			
	HOSPITAL:	مد	OTHER:					
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Ou 28e. DATE OF INJUM (Month, Day, Yeer) 28e. PLACE OF INJUI building, atc. (Sp	28b. TIM	4 Nursing H E OF URY M 1	lome 5 Reeldence INJURY AT WORK? YES 2 NO	28d. DES	(Specify) CRIBE HOW INJURY TION (Street end Num Town, Stete)		Route Number,
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 5 Could not be 4 Homicide determined	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, atc. (Sp.	28b. TIM INJ Y — At home, farm, secify)	4 Nursing H E OF 28c. HURY M 1 street, lactory, or	INJURY AT WORK? YES 2 NO	281. LOCA	CRIBE HOW INJURY CTION (Street end Nun r Town, Stete)	nber or Rural	

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BALTIMORE, MARYLAND 21215-0020 burs after death. Page 6 may be retained by the hospital or attending physician.

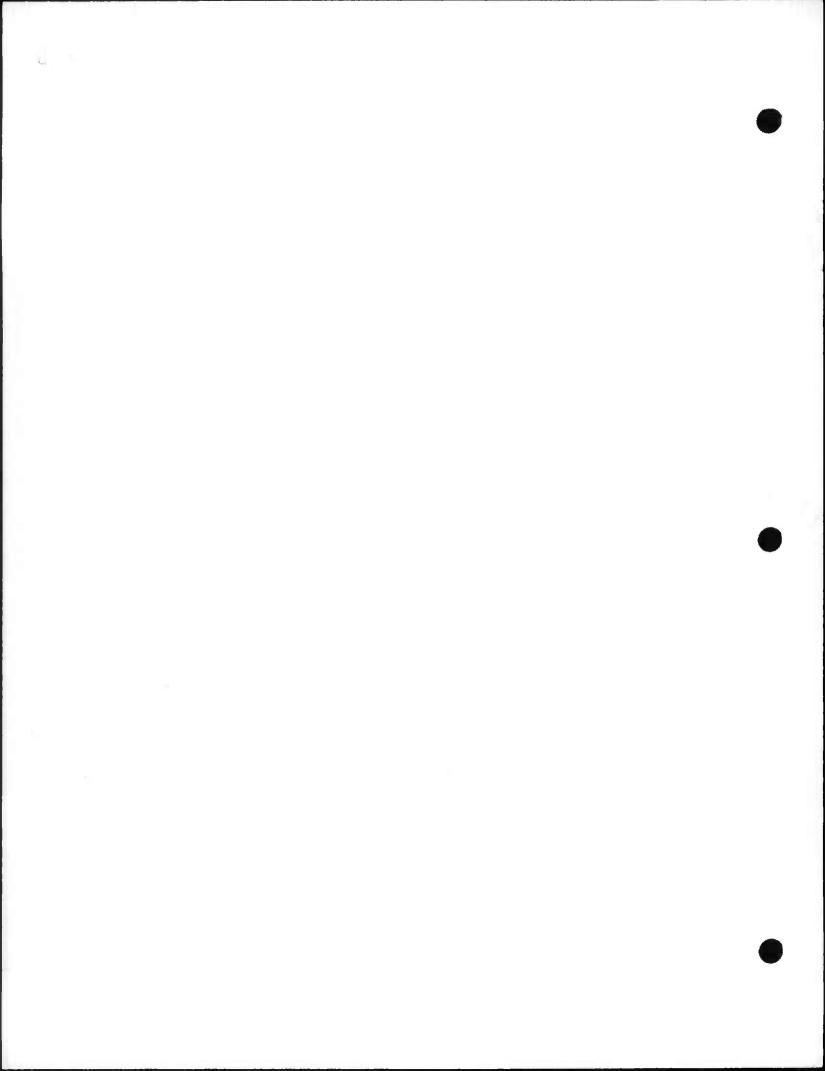
AM	ended #16B and FOR 1 - STATE 1 - REGISTRAR	STATE OF MAR	YLAND / DEI	PARTMENT	County, OF HEALTH A OF DEAT	AND MEI	NTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, I	innette	Cc	ppe)c	DATE OF DEATH	, 1995				
	21936 6635 9a. FACILITY NAME (If not institution, g	GE (In yrs. lest birthe	S. MONTHS	MAYS HOURS DWN OR LOCATION	MIN.	DATE OF BIRTH (Month, Day, Year) anuary 2	8, 194	BIRTHPLACE (State or Foreign Country) Maryland				
TOR.	24887 Lambs Mead	Worto		N OF DEATH		Kent	Y OF DEATH					
DIRECTOR	Maryland 10b. co	Kent		orton	LOCATION				10d. INSIDE CITY LIMITS? 1 YES 2 Y NO			
FUNERAL	24887 Lambs Mead	low Road			10f. ZIP CODE 21678			USA	N OF WHAT COUNTRY?			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	Never Married 2 Married FORCES? 1 YES 2				Maxican, Pu	RIGIN? (Specify Yes arto Rican, atc.)		Black, White, etc. Specify: Black			
COMPLETED	15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12) 12th	EDUCATION trade completed) College (1-4 or 5+)	(Give kind life. Do No	OT use retired.)	JPATION ing most of working		16b. KIND OF BU	rv.				
	17. FATHER'S NAME (First, Middle, Last)		Labor				First, Middle, Maiden	F	actory			
3 BE	Jwefferson Fre	eman Jeilel	rson Fr		treet and Number of	ggie l	Sutler Number, City or Tow	n, State. Zip Co	ode)			
2	Melvin Copper						l, Worton					
	20a. METHOD OF DISPOSITION 1 Denial 2 Cremation 3 1 4 Donation 5 Other (Specify)	Removal from State	20b. PLACE AND DA	TE OF DISPOSITIO	N/Neme of		DATE 20c. LO	CATION — City	y or Town, State			
	1X Burial 2 Cremetton 3 Removal from State Commeter, Cremejory or other place) Mt. Olive A.M.E. Church 10/24/95 Butlertown, St. Budharume of Funeral service licensee 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland											
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST Later the cause of											
MEDICAL C	in Sulin de pend	ng In the under	rlying ceuee giv	ren in Part	I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINOING AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			88. PLACE OF DEA	TH (Check or	ly one)					
IYSI	1 TES 2 NO 27. MANNED OF DEATH	1 Inpetient 2 ER/O			Home 5 Masie	dence 8 🗆	Other (Specify)					
BY PI	1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJUR (Month, Day, Year		INJURY	WORK?		DESCRIBE HOW I	IJURY OCCUR	ED			
a	2 Accident 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.											
OMPLET	(Check only		tion and/or investig	ation, in my opini	on, weath occurred		and the same of the same	29d. DATE SIGNED (Month, Day, Year)				
BE COMPL	(Check only	IINER: On the beals of exeminal	tion and/or investig	etion, in my opini	29c. LICENS	SE NUMBER		29d. DATE SI	GNED (Month, Day, Year)			
E COMPL	(Check only one) 2 MEDICAL EXAM	FIED ON the beale of examined FIED OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF THE PORT OF T	DEATH (ITEM 27) (7	ype, Print)	29c. LICENS	SE NUMBER	7	29d. DATE SI	GNED (Month, Day, Year) 0-19-95 Chestertown			

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FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			REGISTRAR	_			CERTIF	ICATE	· UF	DEAL	п		REG. NO.			
		Ιí	1. DECEDENT'S NAME (First	, Middle, Last)									OF DEATH			3. TIME OF DEATH
			Benjamin	Frankl	in Carli	10					j,	MONTH			YEAR	1 10704 #
			4. SOCIAL SECURITY NUME	Lanki	5. SEX						_	Nov	~ ~ ~ ~			<u>J:13PM</u> ■
						6. AGE (In	yrs, last birthday)	IF UNDER MONTHS	1 YEAR DAYS	IF UNDER 2	MIN.		Dey, Year)		e. BIRTH Country	PLACE (State or Foreign
			213-22-372	/	1 🔀 M 2 🗌 F	68	YRS.	mount in	UNIO	HOUNS	wire.		27, 1	026		W.VA.
	3 should		9a. FACILITY NAME (If not in	astitution, give s	treet and number)			9b. CITY.	TOWN	OR LOCATION	N OF DEA		2- 1 g I	9c. COUN	TY OF D	FATH
	38	œ	15	1 D	1 0		_							30. COOK	TT OF DE	EATH
		2	15 mile Cre	ек коа	d, Green	ridge	Forest	F1:	inte	stone				A11	Legar	nv
	- S	<u>හ</u>	10a. STATE	10b. COUNT			I was on				-					
	oor.	DIRECTOR						TY, TOWN O								10d. INSIDE CITY LIMITS? TOTAL
	7		MARYLAND	لللم	EGANY		l l	LINT	STON	1E			1			1 YES 2 THO
	permit. Pages 1, 2,	4	10e. STREET AND NUMBER				101. ZIP CODE					10g. CITIZEN OF WI			/HAT COUNTRY?	
	Sit	2	13302 ELBI	NSVILL	F ROAD N	F				21530)				S.A	
	physician. bunal-transit	FUNERAL		ND V I III											, D • M	•
0	rial	5	11. MARITAL STATUS	wardle.	12. WAS DECEDEN FORCES? 1	TEVER IN	U.S. ARMED	13. y	MAS DEC	CENDENT OF pecify Cuban,	HISPANIE	CORIGIN	(Specify Yes	or No-	14. RACE	- American Indian, White, etc.
0	P P		1 Never Married 2 📉		IF YES, GIVE V	MAR OR DAT	TES .			2 X NO			ican, etc.)			WHITE
5-0020	ding the	ВУ	3 Widowed 4 Divo	rced	∣ WW11 U	.S.AR	MY			PK					-	WILLE
-	e as	8	15. DEC	EDENT'S EDU	CATION		16a. DECEDENT'S	USUAL OC	CUPATIO	ON		16b	KIND OF BUS	RINESS/INDI	ISTRY	
2121	or att	COMPLETI		y highest grade			(Give kind of life. Do NOT u	work done a	turing mo	ost of working					, , , ,	
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닐	cher che		9		MARILAND STATE HIGHW						VEXT I	74. 1.		mio i	11017	MI GIIIIK
A	the hospit detached once.	2	17. FATHER'S NAME (First, M								iddle, Malden	Surname)				
Z	क्र दे		ALBERT CARLILE SUSAN									HELLY	ζ			
MARYLAND	ould ould	8	19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
3	r retained by the hospital or attending physician. 5 should be detached for use as the burial-tran notified at once.	2	SADIS CARL				13302	FLBI	INCL	TILLE	ROAT) FT	NTCTO	NF MA	DVT	AND 21530
		·					13302		LIVIDV	TDDL	KOM	, 101	LIVIDIO	INL TIE	11(11)	AND 21330
æ	may r. pa		20g, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION /Neme of OATE 20c, LOCATION — City or To										ity or To	wn, State		
0	ector, p		t X Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) GLENDALE CEMETERY NOV 8 1995 FLINTSTONE MA											ARVI.AND		
2	Pag di di		21. SIGNATURE OF FUNERAL SERVICE LICENSIA. 22. NAME AND ADDRESS OF FACILITY											TICL DILLIO		
5	death. Pag tuneral dii J.	- 1	MERRITT-ADAMS FUNERAL HOME													
BALTIMORE,			Dal	20	111011	XX.									MAT	RYLAND
ш	after the phy		23. PART I. Enter the di	seeses, or o	combilications the	t coursed	the death Do	not enter	the mo	de of dula	O DIT	as soul	COMBE	MIMIL	PLEXI	
	hours after ed in by th or remova medicai	1	ehock, or he	eert feliure.	Liet only one ceu	ree on eac	ch line.	not onto	tile illo	de or dynn	y, auch	ea Caru	ec or reepi	ratory arre	Met,	Approximata Interval Between
		- 1	IMMEDIATE CAUSE (Fire	nei												Onset and Death
	atio		disease or condition	→	Self in	flic	ted gun	shot	wou	nd to	the	hea	d			sudden
68760	executed within 24 I and completely fille burial, cremation, natic event, the	1	resorting in quatry	,			CONSEQUENCE O				_					
37	executed and com to burial, matic ev	_											į,			
9	ertificate be execute ing physician and c giene prior to buria other traumatic	CERTIFICATION	Sequentially list conditions, Major depression Due to (OR AS A CONSEQUENCE OF):									l year				
	tan a	FI	if any, leading to immed		502 10	(OR AS A C	ONSEUDENCE O	ii-):								1
B	ate pri bri	<u>0</u>	CAUSE (Disease or inju		с											
Ö	the plant	<u> </u>	that initiated events		DUE TO	(OR AS A C	CONSEQUENCE O	F):								
P.0	Hydir e	E	resulting in deeth) LAS	1.50	d.											
10	the death certificate be to the attending physician dimental Hygiene prior to Injury, or other traun	2														
ORDS,		7 1	PART II. Other aignifice	nt condition	s contributing to	death but	t not resulting	in the und	deriying	g cause giv	ven in P	art I.	24a. WAS AN			WERE AUTOPSY FINDINGS
H	# 5 G - 1	EDICAL	S/P AK amp	utatio	n right	Ter t	for bone	a film	or i	V0020			PERFOR	1		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ö	uires tha signed Health a	0					LOI DOM	<u>C C CIII</u>		ycars		-	1 YES 2	> 00		OF DEATH?
Ë	of H show	Σ										_	/			1 TYES 2 NO
<u></u>	PHYSICIAN: The law requires this certificate has been signed with the State Dept. of Healt ried, or item 23 shows	SICIAN:	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH Y	ES 🗆 N	10 E	UNCE	RTAIN					
VITAI	a be De	≤	25. WAS CASE REFERRED TO	MEDICAL		20	B. PLACE OF OEA	TH (Check o	nly one)							
	N: The ficate has State D	₩ ₩	EXAMINER?		HOSPITAL: t ☐ Inpatient 2 ☐	EDIO		OTHER				V.	C	roonr	idaa	forcat
>	the the	ΞI	27, MANNER OF DEATH		28e. DATE OF						V -			-		forest
OF	his ced	PHY		Pending	Nov 5,	my, Year)	28b. TIR	JURY		URY AT	- 1		RIBE HOW IN			
Z	After this death with	B		renging investigation	Nov 5,	1995) [1.	A00:1	1 🗌 1	YES 2 🔀	NO 3	elf	inflic	cted g	guns	hot wound
DIVISION			a Contact -	Could not be	28a. PLACE O	F INJURY ~	- At home, ferm,	street, facto	ry, office			281. LOCA	TION (Street a			
S	after after	E I		determined	State	arc. (Specify	()					15 m	Town, State)	cools I	D.d.	FlintstoneM
\geq	OR ATTEN DIRECTOR: hours after item 28 i	<u> </u>	On OFFITIER						-			-				FIIILSCOREM
	1 P P P	릴미	29a. CERTIFIER (Check only	IFYINO PHYSI	CIAN: To the best of	my knowled	dge, death occurr	ed at the tir	ne, date	and place, a	and due to	the ceue	e(a) and men	ner se stated	d.	
	ERAL in 72 if 17: If	COMPLE														and manner as stated.
	TO THE HOSPITAL TO THE FUNERAL I DE filed within 72 h IMPORTANT: If I												,			
	世世夏	BE	296. SIGNATURE AND TITLE	THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRE		1				29c. LICEN	SE NUMB	ER		29d. DATE	SIONED	(Month, Day, Year)
	TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: IF		KKL	1/1	/-			\mathbf{D}_{1}	pty	Med E	Ex D	0915	7	Nov	5,	1995
(7	2	10 HAME AND ADDRESS OF	PERSONNE	COMPLETED CAUS	SE OF DEAT	H (ITEM 27) (Type	, Print)	- 1						- ,	
10), [Paul Sno	1/			st Cumb		2150	12						
1/1/	$U \mid$		31. DATE FILED (Month, Day,					, riu ,	C I J (
40	2		NOV 07	1000	42. REGISTRA	S SIGNAT) A									
			140 A A (INN	THUM DUTIN	DULINE ST	andall.									I



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

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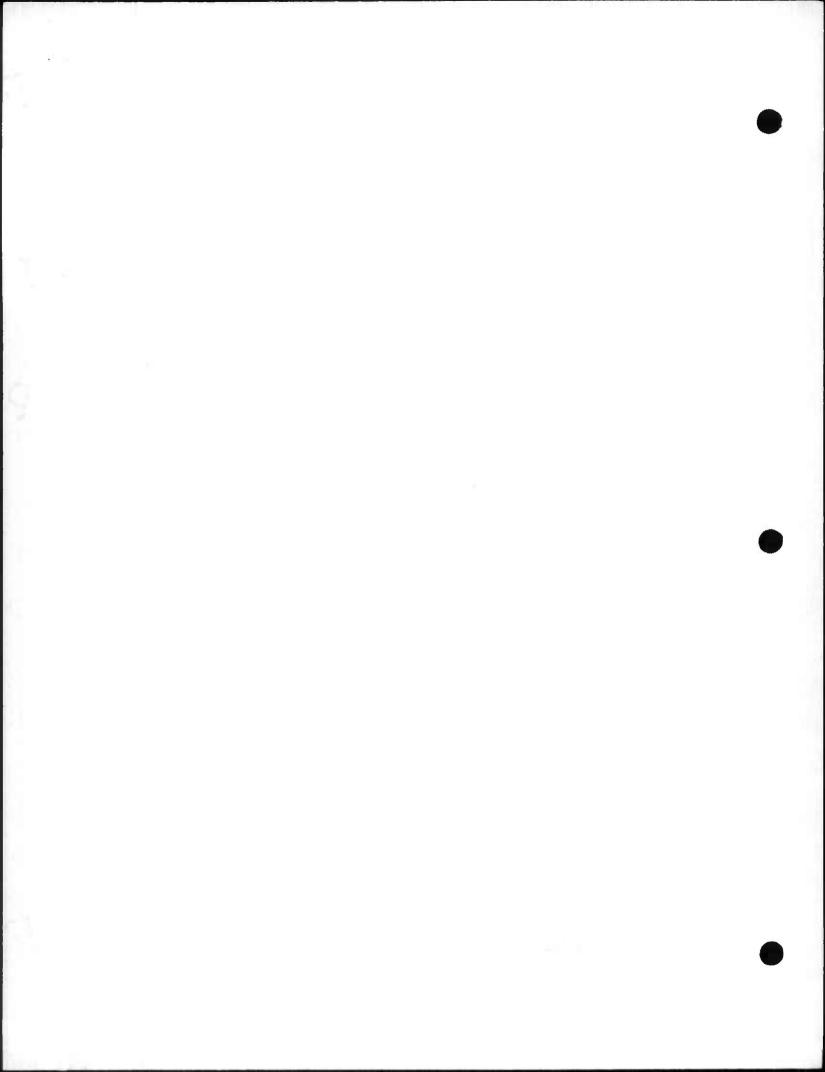
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	ICATE OF	DEATH		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)		-					OF DEATH	AV	VEAD	3. TIME OF DEATH	
		CALLIS, S	R.				NÖVÏ	MBER "	Ĭ1, 1	995	11:11 Pm	
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		6. BIRTH	IPLACE (State or Foreign	
	216-14-1469	1 M 2 F	75	YRS.	MONTHS DAYS	HOURS MIN.	SEPI	1. Day. Year)	1920	MAI	RYLAND	
	9a. FACILITY NAME (If not institution, give s	street and number)			96. CITY, TOWN	OR LOCATION OF D			9c. COU	NTY OF D	DEATH	
DIRECTOR	GARRETT COUNTY M	EMORIAL H	OSPITAL	TAL OAKLAND						GARRETT		
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT											
<u>E</u>		ARRETT		10c. CITY	TOWN OR LOCAT						10d. INSIDE CITY LIMITS?	
		ARRETT		OAKLAND						1 🖔 YES		
¥.	10e. STREET AND NUMBER	_			10	. ZIP CODE					WHAT COUNTRY?	
FUNERAL	308 WOODLAND DRIV					21550			U	SA		
준	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARI	MED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN	7 (Specify Yea	or No-	14. RACI	E — American Indian, k, Whita, stc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WI	IR OR DATES			2 NO Speci		ncan, atc.)		Speci	the:	
		WW I									" WHITE	
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade	completed)	18a. DEC	VE kind of w	USUAL OCCUPATION ork done during more retired.)	ON ost of working	.16b.	KIND OF BUS	SINESS/INC	DUSTRY		
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)			e retired.) LLE DEAL			ATITO	MOBI	TEC		
ž l			AUT	OMOD.	LLE DEAL					LED		
8	17. FATHER'S NAME (First, Middle, Last) JOSEPH EDWARD C.	ALLIS				18. MOTHER'S NA						
BE		CELIA		STUR								
2	19a. INFORMANT'S NAME (Type/Print)					and Number or Rural						
	MARY L. CALLIS				OODLAND		AKLAN.	D, MD				
	20a. METHOD OF DISPOSITION 1. Burlel 2 Cremation 3 Rame	oval from State	20b. PLACE A	ND DATE O	F DISPOSITION (Na	ame of	DATI					
	4 Donation 5 Other (Specify) OAKLAND CEMETERY 11/14 OAKLAND, MARYLAND											
	21. SIGNATURE OF HERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY P.O. BOX 243											
	MO0167 DURST FUNERAL HOME - OAKLAND, MD 21550											
	23. PART i. Enter the diseases, or o	complications that	council the de-									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line.											
	anock, or maint failure.	Liat only one caus	e on each line.	ath. Do n	ot antar tha mo	da of dying, suc	ch aa card	iac or reapi	ratory ari	eat,	Approximate interval Between	
ŀ	iMMEDIATE CAUSE (Final disease or condition	List only one caus	e on each line.	ath. Do n	ot antar tha mo	,		/			Interval Between	
	iMMEDIATE CAUSE (Final	a. My	O Car	L	al	,		/			Interval Between	
7	iMMEDIATE CAUSE (Final disease or condition	a. My	or AS A CONSEO	L	al	,		/			Interval Between	
NOI	iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	a. A Late to (to	O Car	UENCE OF	ral :	,		toov			Interval Between	
CATION	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. A Late to (to	OR AS A CONSEC	UENCE OF	ral :	,		/			Interval Between	
IFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. V Control on a cause of the to (control of the t	OR AS A CONSEC	UENCE OF	ral motre	,		/			Interval Between	
ERTIFICATION	iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. V Control on a cause of the to (control of the t	OR AS A CONSEO	UENCE OF	ral motre	,		/			Interval Between	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the intending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

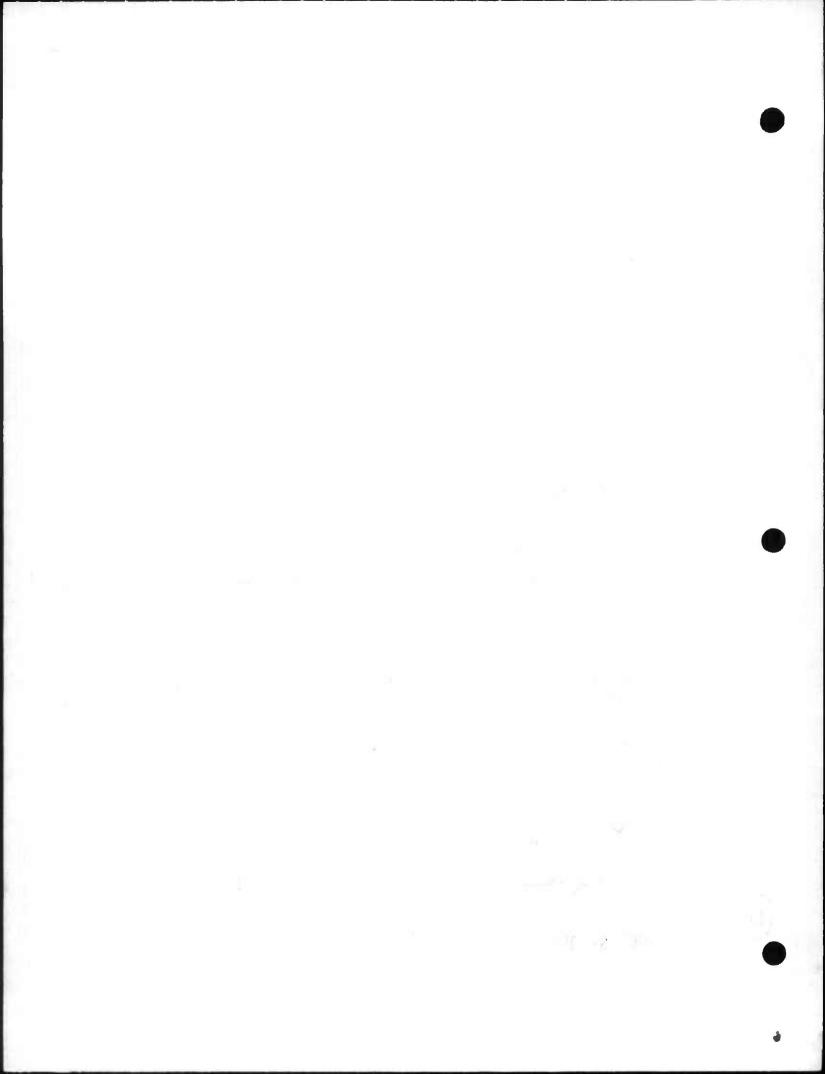
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - STATE REGISTRAR	STATE OF MARYLAND /		MENT OF HI		MENTAL HYGIENI REG. NO.	E					
	1. DECEDENT'S NAME (First, Middle, Last)	DAVIS		OAIL OI	DEATT	2. DATE OF DEATH MONTH	2 9 YEAR	3. TIME OF DEATH				
	0 0 -	SEX 6. AGE (In yrs. Ia.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month! Day, bear)	6. BIR	THPLACE (State or Foreign intry) N.C.				
	9e. FACILITY NAME (If not institution, give street	10		9b. CITY, TOWN OF	R LOCATION OF DE		9c. COUNTY OF					
OR	Anne Arundel Med	dical Center		Annap	olis		Anne A	rundel Co.				
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY.	10d. INSID€ CITY								
	MD AA		A	NNAPO	ZIP CODE	10g. CITIZEN OF	LIMITS?					
FUNERAL	3417 COHAS	SET AVE			2140	73	U	SA				
B⊀	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. AI FORCES? 1 X YES 2 IF IF YES, GIVE WAR OR DATES		If yes, spe		HC ORIGIN? (Specify Yea n, Puerlo Rican, etc.) /:	Bi	ICE — American Indien, ack, White, etc.				
COMPLETED	A STATE OF THE PARTY OF THE PAR	mpleted) ((C) life College (1-4 or 5+)	Give kind of wi e. Do NOT use		N t of working	16b. KIND OF BUS						
OMP	10th 17. FATHER'S NAME (First, Middle, Last)		Truck	Driver	IS MOTHED'S NA	ME (First, Middle, Maiden	Food S	tore				
BE C	Columbus Davis					a McWillia		s				
20	19e. INFORMANT'S NAME (Type/Print)	15				Route Number, City or Town		0.0				
	Evora D. Davis	205 81 405		Cohasse		nnapolis,	Md 214					
	1 St Burlel 2 Cremellon 3 Remova 4 Donation 5 Other (Specify)	remetery, cr. Davis	remetory or oth Fami	Ly Cemet	ery 11/1	10/95 Enfi	Leld, NC					
	1 to Burlet 2 Cremellon 3 Removal from State 4 Donation 5 Other (Specify) Davis Family Cemetery 11/10/95 Enfield, NC 27823 21. SIGNATURE OF TUNERAL SERVICE LIDENSIES 27. SIGNATURE OF TUNERAL SERVICE LIDENSIES 28. NAME AND ADDRESS OF FACILITY											
	Cofield Funeral Home Enfield, NC 27823 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate											
	23. PART I. Enfer the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) e. Metastatic Hepsto Cellular Curcinoma											
N.	DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION												
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ERI	resulting in deeth) LAST	Colorica	100	acce	ea ca	1100						
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PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLA		H (Check only one)		Y- I						
YSIC	I YES 20 NO	IOSPITAL: Inpatient 2 ER/Oulpatient	3 🗆 DOA	OTHER: 4 Nursing Home	5 🗆 Rasidenca	6 Other (Specify)						
	27. MANNEY OF DEATH 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b, TIME INJU	JRY WO	RK?	28d. DESCRIBE HOW II	NJURY OCCURED					
В В	2 Accident Investigation 3 Suicide 8 Could not be	26e. PLACE OF INJURY At h	ome, ferm, at		ES 2 NO	26f. LOCATION (Street &	and Number or Run	al Route Number,				
	4 Homicide determined	building, etc. (Specify)				City or Town, State)						
COMPLETED	one)	N: To the best of my knowledge, d On the basis of examination end/or						e(e) and manner ee stated.				
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	WBER	29d. DATE SIGN	ED (Month Day, Year)				
70	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CALLS OF DEATH OF	EM 27) /5-	D-lett.	N319	7+	1///	16/75				
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DIVISION OF VITAL RECORDS, P.O. BOX 6876	The second secon
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- 1	REGISTRAR		CERTIFIC	MENT OF HEALTH AND CATE OF DEATH	REG. NO.						
	DECEDENT'S NAME (First, Middle, Last SOCIAL SECURITY NUMBER	IDA	DANGEL		2. DATE OF DEATH 10718/199						
	103-32-7831	1 ☐ M 2 🖔 F	89 YRS.	UNDER 1 YEAR IF UNDER 24 HRS. NITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Vear) 2/14/190						
TOR	96. FACILITY NAME II not institution, give FOX Chase N 2015 East W RESIDENCE OF DECEDENT	ursing Home est Highway	e 91	Silver Spr		Montgomery					
DIRECTOR	Maryland Mo		10c. CITY, T	own on Location ver Spring		10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
FUNERAL	100. STREET AND NUMBER 2015 East Wes	t Highway		101. ZIP CODE 20910	-10	USA					
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR	S NO	ANIC ORIGIN? (Specify Yes or can, Puerto Rican, atc.) lify:	No- 14. RACE - American Indian, Black, White, atc. Specify: White						
IPLETED	15. DECEDENT'S ED (Specify only highest gree Elementary/Secondary (0-12)		iife. Do NOT use re	done during most of working	New Yo School	rk City System					
BE COMPL	17. FATHER'S NAME (First, Middle, Last) Guiseppi D' 1 19a. INFORMANT'S NAME (Type/Print)	Ettorre		Flor		etri					
TO B	19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Dangel 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8724 Crider Brook Way, Potomac, MD. 20854 20a. METHOD OF DISPOSITION 1										
	23. PART I. Enter the diseases, or shock, or leart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death)	. List only one ceuse on	each line.	enter the mode of dying, su	ch as cardiec or respirete	Intervel Betwee					
ERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CASPIRATION Pneumonic But To (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sub - dural Hematoma DUE TO (OR AS A CONSEQUENCE OF): July To (OR AS A CONSEQUENCE OF): d.										
ايا	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Crand Mal Seizure Disorder, recurrent 1 yes 2 no										
/SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out		Check only one) THER: Nursing Home 5 Residence	8 Other (Specify)						
ву РНУ	27. MANNIER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		28d. DESCRIBE HOW INJU	RY OCCURED					
ETED I	3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF INJUR building, atc. (Spe	Y — At home, larm, stree cify)	rt, factory, office	281. LOCATION (Street and in City or Town, State)	Number or Rural Route Number,					
O BE COMPLETED BY PHYSICIAN: MEDICA	one) 2 MEDICAL EXAMIN	ER: On the besis of examination		t the time, data and place, and dun my opinion, death occured at the		as atated.					
TO BE	29b. SIGNATURE AND TITLE OF CERTIF	Lymo		29c. LICENSE NU D355		29d. DATE SIGNED (Month, Day, Year) 10/27/95					
I - I	30. NAME AND ADDRESS OF PERSON W Susan Mille			sin Ave, Che	evy Chase.M	ID. 20815					
	31. DATE FILED (Month, Day, Year)	32. MEGISTRAR'S SIGI	HATHBOO		2	2.20013					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with honors after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

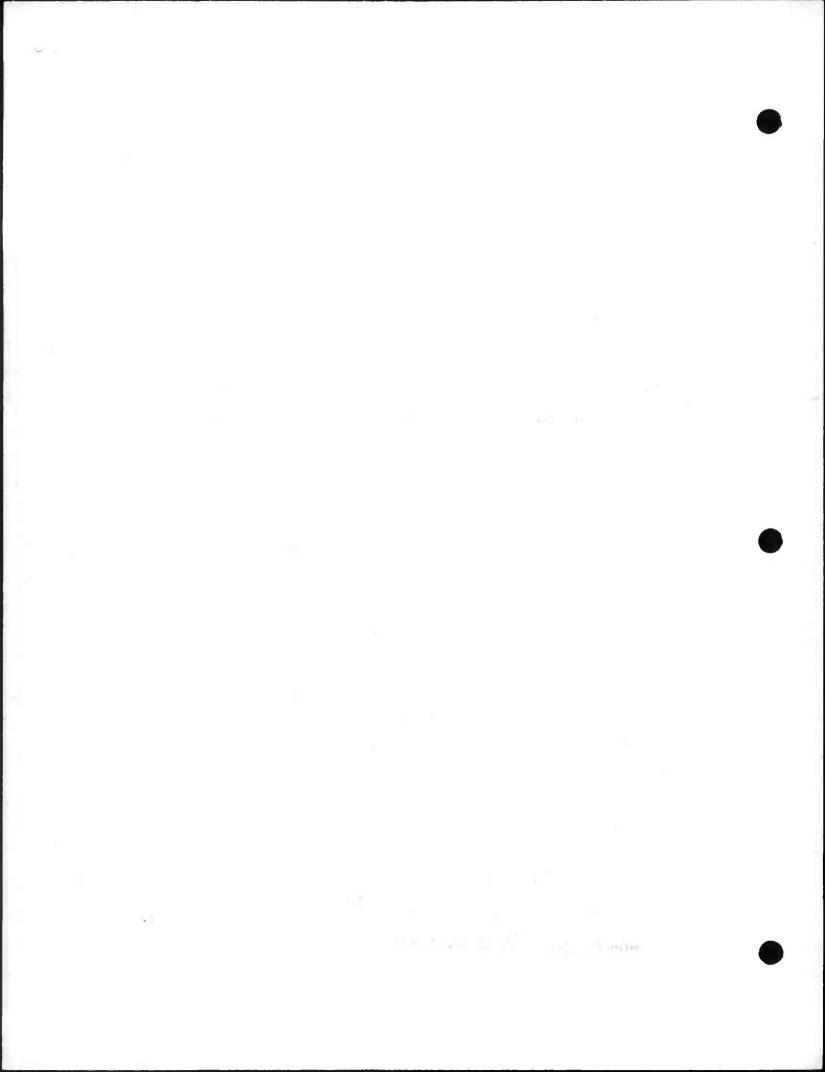
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	HEGISTHAH		CI	EKITF	CALE	UF	DEA	I H	REG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEAT	H DAY	YEA		TIME OF DEATH
	William	Р.		vids	on				Nov.	2,	1995		7:25 P. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH	r)	8. Bi	HTHPL/	ACE (State or Foreign
	221-05-8237	1×XM 2 □ F	78	YRS.	MONTHS	DATS	HOURS	BIFFIE.	(Month, Day, Year 04/20/	17		enr	na.
_	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA						F DEAT	TH .	
6	7847 Public L	anding F	Road		Snow Hill Worcester							ter	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TV		10. 017	, TOWN OF		2011	_					
Ĕ					Snow								d. INSIDE CITY LIMITS?
	Md. Wol	cester		<u> </u>	SHOW							_	YES 2 NO
RA	7847 Public L	anding F	heo?			101	. ZIP CODI			109			T COUNTRY?
FUNERAL	11. MARITAL STATUS	T EVER IN U.S. AR								U.S			
	1 Never Married 2 Married	FORCES? 1	YES 2 T		It	yes, sp	ecify Cubs	n, Maxican	C ORIGIN? (Specify , Puerlo Ricen, etc.		io— 14. R	ACE — lleck, W	American Indian, /hita, atc.
B	3 Wildowed 4 Divorced	IF YES, GIVE V	WAR OR OATES	1 🗆 Y			YES 2 XNO Specify:				s	pecify:	white
		15. DECEOENT'S EDUCATION 16a. 1							16b. KIND OF	BUSINES	SS/INDUSTR	Y	MILLE
<u>L</u>	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	He.	ive kind of w Do NOT use	e retired.)			ng .	Mach	ine	Ope	rat	tor
AP.	9		Cr	Crane Operator					Stee	1 C	Ope Compa	ny	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	-					18. MOTI	HER'S NAM	ME (First, Middle, Ma	den Sums	ame)	-	
BE (William Per	ry David	lson				Sı	ısan	Smale	DAv	ridsc	n	
2	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						•			
-	Elizabeth D	<u>. Davids</u>	on	7847	Puk	oli	C La	andi	ng Rd.,	Sno	w Hi	11	,Md.21863
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, S											State	
	1 Burlet 2 Cremation 3 Removed from State Cametery, crematory or other place) Salisbury Crematory 11/3 Salisbury,												, Md.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home												
	Farricia	P.O. Box 87, Snow Hill, Md. 21863 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	23. PART I. Entar the diseasea, or	complications tha	t caused the de	eath. Do n	ot anter t	he mo	da of dyi	ng, auch	as cardiac or re	spirator	ry arrest,	u.	Approximata
	IMMEDIATE CAUSE (Final Onset and Dear												Interval Between Onset and Death
ŀ	immediate Cause (Final disease or condition resulting in death) a. CHR MIL OBSTRVLTIVE PUL' MEMORY DISTRESE 54P4												
	Toward of the toward	DUE TO	(OR AS A CONSE	OUENCE OF):						7000		
Z	Sequentially list conditions,	b											
CERTIFICATION	if any, leading to immediate	OUE TO	(OR AS A CONSEC	OUENCE OF):								
<u>i</u>	CAUSE (Disease or injury	C. DHE TO	(OR AS A CONSEC	OUENOE OF									1
ËI	that initiated events resulting in death) LAST	DOE 10	(OH AS A COMSE	DUENCE OF):								
		d			_								
	PART ii. Other aignificant condition	ens contributing to	death but not r	reauiting is	n the und	leriying	cauae ç	jiven in P		AN AUTO			RE AUTOPSY FINOINGS
EDICAL	RECEM BRMCK	11715	RIMA	n m	SVFF	:166	WZY			FORMED		co	AILABLE PRIOR TO IMPLETION OF CAUSE
	Excent upper	G-I B1	END										DEATH?
ij	DID TOBACCO USE CON			TH YE	S M N	10 E	UNC	ERTAIN			İ		
룄┃	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEAT									
PHYSICIAN: M	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		5 Y Ro	sidence 8	Other (Specify)				
ᇎ	27. MANNER OF DEATH	28a. DATE OF (Month, D		28b. TIME		2Sc. INJ	URY AT RK?		28d. OEŞCRIBE HO	W INJUR	Y OCCURE)	
BY	1 Natural 5 Pending 2 Accident Investigation				M		ES 2	NO					
	3 Suicide S Could not be	28a. PLACE O building,	F INJURY — At ho etc. (Specify)	me, farm, at	reet, factor	ry, offici			28t. LOCATION (Str City or Town, S	eet and No	umber or Ru	ral Route	Number,
	4 Homicide determined												
ᆲ	29s. CERTIFIER 1 CERTIFYING PHY	my knowledge, de	ath occurre	d at the tim	ne, date	and place,	and due t	o the ceuse(s) and	manner a	s atated.			
COMPLETED	one) 2 MEOICAL EXAMIN	camination and/or i	Investigation	i, in my opi	Inion, d	eath occur	ed at the ti	lme, data and place	, and due	to the caus	10(0) 00	d manner as stated.	
w II	296. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LICE	NSE NUME	BER	29d	. DATE SIGN	IEO (Mo	onth, Day, Year)
∞	Martho	La man	MQ				0	- 5	865	•	11-		
임	30. NAME AND AODRESS OF PERSON W		SE OF DEATH (ITE	M 27) (Type,	Print)						*		,,,
0	ROBERT C. LAMA	R, M.D.,	104 N. I	BAY S	T., S	SNOV	V HIL	L, M	D. 21863				
	31. DATE FILED (Month, Day, Year)	320REGISTRA	R'S SIGNATURE										
	NOV 0 3 1995	Jahin Sa	niem-Rens	heile									
		17											

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND	/ DEPART	MENT OF H	EALTH AND N	MENTAL HYGIEN REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)	DIAMIC	OND			2. DATE OF DEATH DATE						
	4. SOCIAL SECURITY NUMBER 5. S 183-20-5216 1	6. AGE (In yrs. 93		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH SEPT 13,	6 BIE	THPLACE (State or Foreign				
OR B	9e. FACILITY NAME (If not institution, give street er MERIDIAN NURSING				REVILLE		9c. COUNTY OF DEATH QUEEN ANNE					
DIRECTOR	10e. STATE MARYLAND DESCRIPTION 10b. COUNTY MARYLAND	N ANNE		TOWN OR LOCATI				10d. INSIDE CITY LIMITS? 1 X YES 2 \(\triangle \) NO				
FUNERAL	100. STREET AND NUMBER ROUTE 213, BOX	50		101.	ZIP CODE 21617		10g. CITIZEN OF	F WHAT COUNTRY?				
BY	1 Never Married 2 Merried F	WAS DECEDENT EVER IN U.S. / FORCES? 1 YES 2 F F YES, GIVE WAR OR DATES		If yes, spe		IC ORIGIN? (Specify Yeen, Puerlo Rican, atc.)	Sp	CE — American Indian, ack, White, etc.				
ETED.	15. DECEDENT'S EDUCATION (Specify only highest grade compile Elementary/Secondary (0-12) Coll	leted)		BUAL OCCUPATIO k done during mos etired.)		16b. KIND OF BUS						
COMPLET	17. FATHER'S NAME (First, Middle, Last)	-0- Н	OMEMA	KER	14 MATHERIC NAL	OWN RE (First, Middle, Maiden	HOME					
BE C	HOWARD WILSON					BETH KOHL						
5	190. INFORMANT'S NAME (Type/Print) MARGARET DIAMOND					oute Number, City or Town		21610				
	20g METHOD OF DISPOSITION	1 A Buriet 2 Cremation 3 Removal from State										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEI			L an MARKE AND	ADDRESS OF FAC	NEWNAM	FUNER					
NO	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heert feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
N: MEDICAL	PART II. Other eignificant conditione con CO DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL	relicovesion in Suran	lun	epend D NO 13	cause given in F	PERFORI	MED?	4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
HYSICIA		SPITAL: Inpatient 2 - ER/Outpatient	0	THER:	5 - Residence 8	□ Other (Specify)						
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	Y WOR		28d. DESCRIBE HOW IN	JURY OCCURED					
9	2 Accident investigation 3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Bural Route City or Town, State)											
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 1	To the best of my knowledge, of the basis of examination end/or						o(s) end menner as stated.				
IO BE C	296. SIGNATURE AND TITLE OF CERTIFIER CLOSE OF PERSON WHO COM 30. NAME AND ADDRESS OF PERSON WHO COM	Soun	41	nD	D 319			p (Month, Day, Year)				
	GEORGE M.	DUNG 32. BEGISTRAR'S SIGNATURE	EM \$17 (Tron. Pri	CHE	STERT	OWN,	MP	21620				



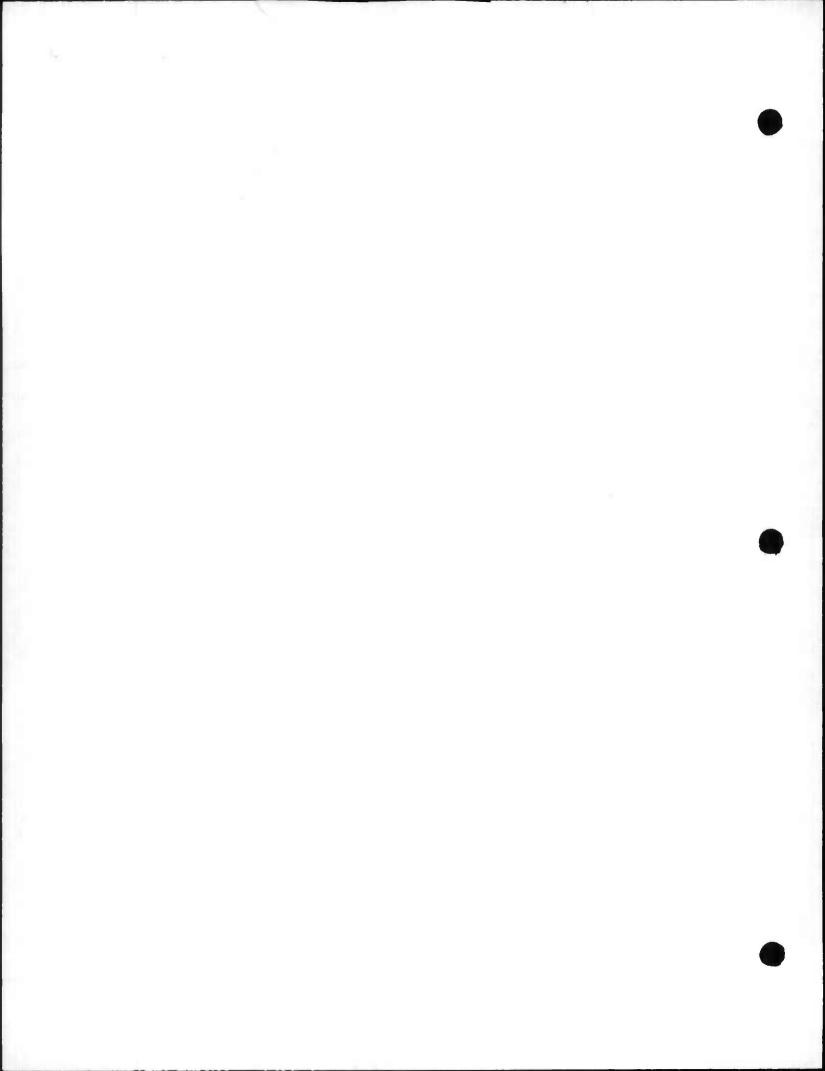
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE OF				3. TIME OF DEATH
		Allison	Kirs	tine	EVANS						монти 1.1	08		995	6:35 a m
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs	s. last birthday)	IF UNDER	T YEAR	IF UNDE	24 HRS.	7. DATE OF	BIRTH		6. BIRTHE	PLACE (State or Foreign
		213-64-755	6	1 🗌 M 2 🔀 F	44	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb.		1951	Rho	de Island
		9e. FACILITY NAME (If not in	nstitution, give e	treet and number)			96, CITY	r, TOWN	OR LOCATI					NTY OF DE	
	CTOR	Rt. 219, Sc	outh a	t Mason	School	Road	0a	klan	ıd				G	arret	t
- 1	ш	RESIDENCE OF DEC	10b. COUNTY	,		10c, Ci	TY, TOWN (OR LOCA	TION						10d. INSIDE CITY
	E I	MD	Ga	rrett						klan	d			- 1	LIMITS?
	- - 1	10e. STREET AND NUMBER		11000				10	1. ZIP COD		<u>u</u>		10a, CIT		HAT COUNTRY?
	ERA	5923 George	e Wash	ington H	ighwav					2155	0			USA	
	FUNE	11. MARITAL STATUS		12. WAS DECEDED FORCES?		ARMED			CENDENT (OF HISPAN	IC ORIGIN? (S		or No-	14. RACE	- American Indian,
	ВУ	1 Never Married 2 3 Widowed 4 X Divo	MINO			2 XNO		n, Puerto Rica	in, etc.)		Specify	White, etc.			
	ا ۵	15. DEC	10.0	. DECEDENT'S	2 HEHAL O	COMPATI	011						White		
	ETE	(Specify ont		(Give kind of life. Do NOT L	work done	during mo	ost of working	ng	166. KH	ND OF BUS	SINESS/INI	DUSTRY			
	립	ciementary/secondary (c	0-12)	College (1-4 or 5		Nursin	12				Re	egist	ered	Nurs	se.
at once.	COMPL	17. FATHER'S NAME (First, M			0		18. MOT	HER'S NAI	ME (First, Midd	_		1.01.0			
7	ш	Charles	Patr	ick			M	ary	Ki	irsti	ne	Sc	hwartz		
tiffec	10 B	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
e 10	-	Erik Geroski P.O. Box 342, Thomas, West Virginia 26292												.92	
ust b		20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of complete, cremation or other place)												n, State	
E		4 Donetion 5 Other		evere A	_ Omé	ga Cr					11/9	Mon	rgant	own,	WV
E		Cemeter 2 (A Cremetton 3 Removal from State Cemetery, cremetory, or other place) Cemetery 11/9 Morgantown, WV													
еха		32 S. Second St., Oakland, MD 21550													
edic		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.												Approximata	
E =		IMMEDIATE CAUSE (Final													
a,		resulting in death) and right Sudden													
other traumatic event, the medical examiner must be notified		DUE TO (OR AS A CONSEQUENCE OF): humerus, femur, and ribs.											0 11		
matic	RTIFICATION	Sequentially list conditions, Due to one as a consequence of										Sudden			
trau	\$	If any, leading to immediate cause. Enter UNDERLYING											į į		
the		CAUSE (Disease or Inju thet initiated events		DUE TO	(OR AS A CON	SEQUENCE O	F):								
6		resulting in death) LAST													
594	- 19	PART II. Other significent conditions contributing to death but not resulting in the underlying course gives in Bart II.												WERE AUTOPSY FINDINGS	
l k	MEDICAL	PERFORMED? AVAII											WAILABLE PRIOR TO		
W.S.											- ["	YES 2	(XNO	1	OF DEATH?
윤 .	. 1	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF D	EATH Y	FS 🗆 1	NO F	₹ UNC	FRTAIN					I C YES 2 NO
item 23	NAN N	25. WAS CASE REFERRED TO EXAMINER?	1			LACE OF DEA									
	VSICI/	XX YES 2 NO		HOSPITAL:	ER/Outpatien	t 3 🗆 DOA	OTHER 4 - Num	R: sing Hom	e 5 🗆 Re	reldence (6X Other (Sp	High	ıway	#219	
	PH	27. MANNER OF DEATH	March 1	28a. DATE OF (Month, D	INJURY lay, Year)	28b. TIN		28c. INJ							road, crosse
	à	2 Accident	Pending Investigation		8,1995			1 🗆 1	YES 2 2	NO	cente	r lir	ie &r	to pa	ath of truck
.00			Could not be determined	28a. PLACE O building,	F INJURY — At etc. (Specify)	t home, farm,	street, fact	ory, office	•			wn, Stete)			
		20. CENTIFIED	11	High		_									of Oakland
IMPORTANT: If item	COMPL	(Check only		CIAN: To the beat of											
NA S	5			R: Un the beele of a	xamination end	/or investigation	on, in my o	pinion, d	eath occur	ed at the t	lime, date and	place, end	due to th	e ceuse(e)	and manner ee stated.
E E	#	29M SIGNATURE AND TITLE	OF CENTURES		- //	_ 2	-0			NSE NUM					Month, Day, Yber)
₹ 3	2	30. NAME AND ADDRESS OF	E DEBEON WALL	COMPLETED ST	Aldo		2.8	~	D (5658			No	vemb	er 8, 1995
'		Herbert H.						ot	net-1	han	Marso	1 ಇಗೆ ಗೆ	2155	in	
		31. DATE FILED (Month, Day, 1			R'S SIGNATUR		orie	с.,	Daki	.anu,	rial y.	Lauu	21)	-	
100		NOV 0 S			welson										
10		1104 0 6	V 1333	LIGHT CUR	THE PERSON NAMED IN	W TO G. TO									



TO BE COMPLETED BY FUNERAL DIRECTOR

ITEMS:	23 PART	Ι,	27, PER	MEO	FILM	G - 731	1/17/96	t.t
FOR			CTATE	OE M	ADVI A	ND / DE	DADTMENT	COE

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT/ CERTIFICATE OF DEATH	AL HYGIENE REG. NO.

REGISTRAR		CERTIFIC	CATE O	F DEATH		REG. NO.			
1. OECEDENT'S HAME (First, Middle, Last)						OF OEATH		3. TIME OF	DEATH
HEATHER	LOUI	SE	F	RASER N	DVEM			9:02	7
4. SOCIAL SECURITY HUMBER			IF UNDER 1 YEA	I.					
216-70-9222			ONTHS DAY		(Month,	DE BIRTH , Day, Year) -30-60		BIRTHPLACE (Stete Country) Ashingto	
90. FACILITY HAME (If not institution, give s	TAL		96. CITY, TOW	LOR LOCATION OF D	EATH	F		EORGE'S	
3100 GRACEFIELD ROAD SILVER SPRINGS MON									
									CITY
Maryland Mor	ntgomery	S	ilver	Spring				1 🖄 YES	2 NO
3100 Gracefield	Road			20904			10g. CITIZEH	USA	RY?
11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED		DECENDENT OF HISPA				RACE — American	n Indien,
1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YE	DATES		specify Cuben, Mexico /ES 2 NO Specifi		licen, atc.}		Specify: White, etc. Whit	:e
15. DECEDENT'S EDUC (Specify only highest grade		16e. DECEDENT'S U (Give kind of wo	ork done during	ATION most of working	16b.	KIHD OF BUSI	NESS/INDUST	RY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)						
0		Disa	bled				None		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S HA	AME (First, A	fiddle, Maiden S	umeme)		
Emerson	L. Fraser				Shir	cley N.	Russ		
19e. INFORMANT'S HAME (Type/Print)	_			et and Number or Rural Apt. 30					
Emerson L. Frase					9				
20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem 4 Denation 5 Other (Specify)		ob.PLACE AND DATE OF oth emetery, crematory or oth letropolit			_8_9	20c. LOC		or Town, State	nia
21. SIGNATURE OF FUNERAL PERVICE LIC		lectopolit						, , , , , , ,	.11.14
· What I hale			Geo 616	orge P. Ka	las I 11 Ro	Funeral 1. Oxon	Home Hill	, Md. 20	745
23. PART i. Enter tha diseases, or o	complications that caus	sed the death. Do no							oximate
shock, or heart fallura. IMMEDIATE CAUSE (Final disease or condition		C CAUSE OF D	EATH						val Batween t and Daath
resulting in death)	8	S A CONSEQUENCE OF							
Sequentially list conditions,	b. OHE TO (OR A)	S A COHSEQUENCE OF							
If any, leading to immediate cause. Enter UNDERLYING	002 10 (011 20	A CONSCOURNE OF							
CAUSE (Disease or Injury that initiated evanta resulting in death) LAST	DUE TO (OR A	S A COHSEQUENCE OF);						
resulting in duality CAST	d								
PART II. Other algnificant condition	a contributing to death	but not resulting in	tha underl	ying causa given Ir	Part I.	24a. WAS AN A	WTOPSY	24b. WERE AUTO	PSY FINDINGS
						PERFORM		AVAILABLE P	
					_	. 02.20		OF DEATH?	2 THO
DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YES	S NO	☐ UNCERTAI	N 🗆			1 163	2 110
25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATI	H (Check only o	one)					
EXAMIHER? 1 X YES 2 NO	HOSPITAL: 1 inputient 2 ER/0		OTHER:	fome 5 Residence	6 🗆 Othe	r (Specify)			
27. MAHHER OF DEATH	28e. DATE OF IHJUR	Y 28b. TIME	OF 28c.	IHJURY AT	1	CRIBE HOW IH	JURY OCCUR	ED	
KX Hatural 5 Pending 2 Accident Investigation	(Month, Day, Yea	r) INJU		WORK? YES 2 HO					
3 Suicide 8 Could not be	28e. PLACE OF IHJU building, atc. (S	RY — At home, term, at pecify)	reet, fectory,	office		ATION (Street er or Town, State)	nd Number or F	Rural Route Number,	
290. CERTIFIER						-			
(Check only one)	CIAH: To the beat of my kn	owledge, death occurred tion and/or investigation						use(e) end menne	er ee stated.
26 SIGHAT RE AND TITLE OF CENTRAL	_)			29c. LICEHSE HU	IMBER		29d. OATE SI	GHED (Month, Day,	Yeer)
	MA	~		O.C.M		NC		ER 11,	1995
3). NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF						•		
	JR. M.D.		n Str	eet, Bal	time	ore, M	daryla	and 212	201
J. DATE FILED (Month, Day, Year)	A A	CHATURE IN							

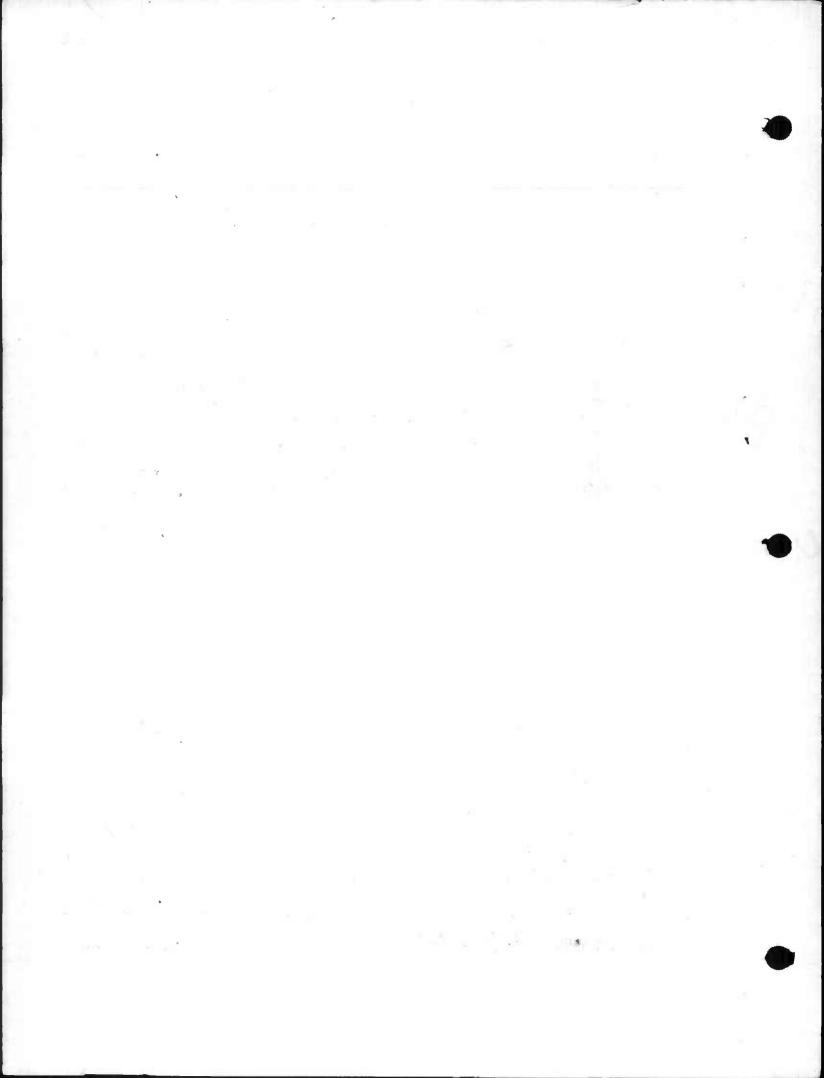
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital on the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



9 TEAR

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Maryland

10d. INSIDE CITY LIMITS?

1XXYES 2 NO

White

Approximate Interval Between

24b. WERE AUTOPSY FINDINGS

1 - YES 2 - NO

AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Onset and Daath

HargorD

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

Specify:

14. RACE — American Indian, Black, White, etc.

235

21	afte
7	0
BALTIMORE, MARYLAND 2121	N. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atte
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ITAL RECORDS, P.O. BOX 68760	dair
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Nem

DIRECTOR: /

TO THE HOSPITAL O
TO THE FUNERAL D
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IMPORTANT: If Its

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(Check only one)

29b. SIGNATURE AND TITLE OF CERTIFIE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH VERNON Woodraw Fadeley SR. 10 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BURTH (Month, Day, Year) Aug. 6,1918 IF UNDER 1 YEAR IF UNDER 24 HRS. 6. AGE (In yrs. last birthday) 717-12-5828 DAYS 1X M 2 F HOURS should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWH OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Havrede 4ar for Memorial Hospita Grace RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWH OR LOCATION Maryland Cecil Perryville the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 2 Ellis Court 21903 nding physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced W.W. II 38 COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY use (Specify only highest Aberdeen Proving Ground ğ Elementery/Secondary (0-12) College (1-4 or 5+) Eleven Years Automotive Inspector Aberdeen, Maryland detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Henry M. Fadeley 2 76 BE Ida Mae Mahan notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nellie B. Fadeley 2 Ellis Court, Perryville, Maryland 21903 9 20e, METHOD OF DISPOSITION
1 S Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE examiner must director, ASbury Cemetery 11/3/95 4 Donation 6 Other (Specify) Port Deposit, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903 completely filled in by the ial, cremation, or removal. traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Lac DUE TO (OR AS A CONSEQUENCE OF) the attending physician and com I Mental Hygiene prior to burial, 40 Ca CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, laading to immediate cause. Enter UNDERLYING MA CAUSE (Disease or Injury injury, or other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY and the PERFORMED? item 23 shows any signed Health 1 - YES 2 NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [X] PHYSICIAN: Dept. has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: 1 TES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 6 the HOSPITAL OR ATTENDING PHYSICIA DIVISION OF 27. MANNER OF DEATH 28b. TIME OF 26a. DATE OF INJURY 28c. INJURY AT WORK? marked, 26d. DESCRIBE HOW INJURY OCCURED this c Natural 1 YES 2 NO After death B 2 Accident 3 Suicide 281. LOCATION (Street and Number or Rural Route Number. 28e. PLACE OF tNJURY — At home, farm, atreet, factory, office building stc. (Specify)

mination and/or investigation, in my opinton, death occured at the time, data and place, and due to the ceuse(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) DOCTOBER, 31,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ITARFORD MEMORIAL HOSPITAL, HAVRE DEGRAGE R.RAO TRIPURANEN! MD

29c. LICENSE NUMBER

190

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 03 1995

2 MEDICAL EXAMINER: On the basis of ax

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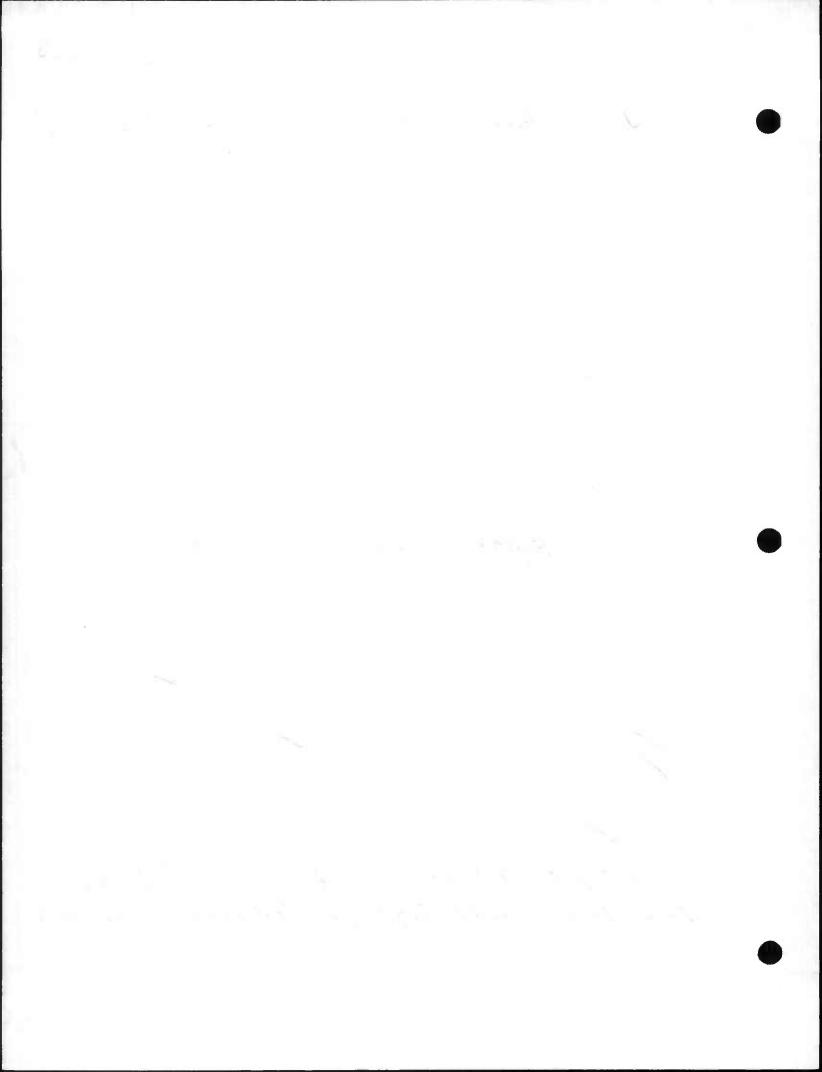
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ADELINE FLATTERY GLADYS OCTOBER 4:00 A M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 71 1 🗌 M 2 🔀 HOURS 028-18-8148 July 4, Massachusetts Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stree 9h. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 6809 Northgate Parkway DIRECTOR Clinton PLINCE GEORGES RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George Clinton permit. 1 TYES TO NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 6809 Northgate Parkway funeral director, page 5 should be detached for use as the burial-transit 20735 United States retained by the hospital or attending physician. 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If year anectiv Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Ri 1XXNever Married 2 Married BY Specify 3 Widowed 4 Divorced 1952-1972 COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTR College (1-4 or 5+) 12 8th Registered Nurse U.S.A.F once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE Mary A. Person Edward F. Flattery, Sr notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joseph Herbert Flattery 41 Linden Street, Lynn, Mass 01905 must be 20b. PLACE AND DATE OF DISPOSITION (Name of NOV 8, 1995 20c. LOCATION — City or Town, State Cemetery, crematory or other place)
Arlington National Cemetery Arlington, Virginia the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 663 Old Alexandria Ferry Road, Clinton,Md 20735 attending physician and completely filled in by the ntal Hygiene prior to burial, cremation, or removal. 23. PARTA. Enter the dise omplications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fellure. List only one cause on each line interval Between IMMEDIATE CAUSE (Finel Onset and Death disease Dr condition MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSCOUENCE OF): resulting in death) executed within event, MINKLOA CORONARY HEART DISEASE traumatic CERTIFICATION years Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 signed by the atte Health and Mental PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? Charme Obstructive Pulmoniany Disease 1 TYES 2 NO NO OF DEATH? 1 - YES 2 - NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO K UNCERTAIN s certificate has be th the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 Dinpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? this c marked, 26d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 1 YES 2 NO BY After death ATTENDING Investigation DIRECTOR: Af hours after de item 28 is r 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide OR 29e. CERTIFIER 1 🗌 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner ea stated. (Check only one) HOSPITAL FUNERAL within 72 I 900 TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) & Suyer MO D25925 Detober 30, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 Wisconsul Ave BeThesda, Md 208/ 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE ... Fully d'audion-Rardoll

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, MARYLAND 21215-0020	within 24 hours after death. Dans 6 may he retained by the hooniest or retearling about its
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REGISTRAR CERTIFICATE	OF HEALTH AND MENTAL HYGIENE OF DEATH REG. NO.									
1. DECEDENT'S NAME (First, Middle, Lest) Jogn Ashby Frasher 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In use lest hithdeal) 5. NAME (In use lest hithdeal	09010131,1990 12									
192-30-4224 1 M 2 💢 F 56 YRS. MONTHS DA	Feb 16, 1939 West Virginia									
6804 Collinson Court Ca	own or Location of Death amp Springs oc. COUNTY OF DEATH Prince George's									
HESIDENCE OF BECEBENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR L 10c. STREET AND NUMBER 10c. STREET AND NUMBER	LIMITS?									
5 E 6804 Collinson Court	107. ZIP CÓOE 10g. CITIZEN OF WHAT COUNTRY? 20748 United States									
1 □ 1 □ 1 □ 1 □ 1 □ IF YES, GIVE WAR OR DATES	S DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- es, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify: White									
15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Faitor Faitor	JPATION 16b. KIND OF BUSINESS/INDUSTRY									
The second of th	Magazine 16. MOTHER'S NAME (First, Middle, Maiden Surname)									
19. Informant's NAME (Type/Print) 19. MAILING ADDRESS (ST 19. MAILING ADDRESS (ST 19. MAILING ADDRESS (ST 12.0.3.3.7. De	LaRue L. (UNKNOWN) Itroet and Number or Rural Route Number, City or Town, State, Zip Code) alisades, Dunkirk, Md 20754									
20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION	ON (Name of NOTZ 6 1905)									
The support of Funeral Service Licenses 22. NAM Old 23. PART Lenter the diseases, or complications that caused the death. Do not enter the	22. NAME AND AODRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735									
IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (or as a consequence of):	a mode of dying, such as cerdiac or respiratory arrest, Approximate interval Betwee Onset and Deat									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO										
T 27. MANNES OF DEATH 28s. DATE OF INJURY 28b TIME OF 12s	Home 5 PRasidence 8 Other (Specify) c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED									
1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, building, etc. (Specify)										
29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time	City or Town, State) data and place, and due to the cause(s) and manner as stated,									
E A C = S (Orie)	ion, death occured at the time, data and place, and due to the cause(s) and manner as stated.									
MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion on the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation or investigation of examination and or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or inves	20C LICENSE NUMBER 204 DATE SIGNED (Month One Want									
THE SECOND ONE 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinic 2. MEDICAL EXAMINER: On the basis of examination and/or investigation and on the basis of examination and/or investigation and on the basis of examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examination and or examina	200. DATE SIGNED (Month, Day, Year)									



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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - REGISTRAR CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last) CATHERINE ROS	A LEE FORBES		2. DATE OF DEATH DAY OCTOBER 23, 1995						
	370 10 3000	578-48-3606 1 M 2 X F 67 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) OCT.10,19								
TOR	9a. FACILITY NAME (If not institution, give street and r PRESIDENTIAL WO RESIDENCE OF DECEDENT	NURSING		ELPHI	АТН	PRINC	CE GEORGE'S			
DIRECTOR	10a. STATE 10b. COUNTY	GEORGE'S	city, town on Locat		cs	A	10d. INSIDE CITY LIMITS? 1 XYES 2 NO			
FUNERAL	10. STREET AND NUMBER 505 Suffolk Ave.		101	20743		10g. CITIZE	N OF WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married FOR	S DECEDENT EVER IN U.S. ARMED ACES? 1 YES XX.NO ES, GIVE WAR OR DATES	If yes, sp	ENDENT OF HISPAN polity Cuban, Maxico 2 (X NO Specify						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed (Parentary/Secondary (0-12) College 7 th	(Give kin- life. Do Ni	NT'S USUAL OCCUPATION of of work done during mo OT use retired.)	DN st of working		BUSINESS/INDUS				
	17. FATHER'S NAME (First, Middle, Last) THOMAS S. FOR	BES			ME (First, Middle, Maid CRAWF)					
TO BE	19a INFORMANT'S NAME (Type/Print) JAMES CARROLL, J		ILING AOORESS (Street a				20772			
	20a. METHOD OF DISPOSITION 1 Startel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece) HARMONY MEMORIAL PARK10-28-95 LANDOVER, MD									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE JUMBER AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD20785									
	23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. RENAL FAILURE OUR TO (OR AS A CONSEQUENCE OR):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Due to (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL CI	PART II. Other algorificent conditions control Sepsis	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO							
AN: N	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL		YES NO DEATH (Check only one)] UNCERTAI	N 🗆					
PHYSICIAN:	1 YES 2 XNO 1 In	PITAL: petient 2 ER/Outpetient 3 Description Description			8 Other (Specify)					
ву рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	INJURY WO	URY AT DRK? YES 2 NO	28d. DESCRIBE HO	W INJURY OCCU	INJURY OCCURED				
ED	2 Accident 3 Suicide 8 Could not be datermined 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)									
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledga, death occurred at the time, data and place, and dua to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.									
BE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBER D25977			29d. DATE SIGNED (Month, Day, Year) ▶ 10/23/95			
10	30. NAME AND ADDRESS OF PERSON WHO COMP DR. A. DASHOTTAR	7207 HANOVE	R PKWY	REENBE	LT,MD	20770				
	31. DATE FILED (Month, Day, Year) 32 OCT 3 0 1995	. REGISTRAN'S SIGNATURE O	all							

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FOR

STATE OF MADVIAND / DEPARTMENT OF UPAITU AND MENTAL HYDERS

	1 - STATE REGISTRAR	OINIE OI	CE	RTIF			DEAT		WENTA	REG. NO					
1	t, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIM									3. TIME	OF DEAT	н			
- 6	DOUGLAS	WALTE	ER	FF	RANK	LIN			OC		4.	1995	3:	42	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lesi	t birthday)	IF UNDER		IF UNDER		7. DATE			8. BIRTH Count		ap or Fo	reign
Ŋ	219-78-2527	1 XM 2 - F	35	YRS.	MONTHS	DAYS	HOURS	MIN.	No	V L (1959	Nor	th"E	ärc	lir
	9a. FACILITY NAME (If not institution, give		2012		-		R LOCATIO		ATH		9c. COU	INTY OF D	EATH		
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EC	10e. STATE 10b. COUNT	Ϋ́		10c. CI	Y, TOWN	OR LOCAT	TION						10d. JNSI	DE CITY	
DIRECTOR	Maryland Prin	ce Geor	ges	Tem	ple	Hil	lls							TS?	NO
	10e. STREET AND NUMBER		-			101	. ZIP CODE	E			10g. CIT	TIZEN OF V	VHAT COU	NTRY?	
ER	2502 Dawson Ct	•					207	48				USZ	A		
BY FUNERAL	11. MARITAL STATUS t Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES?	NT EVER IN U.S. ARI t □XYES 2 □ N WAR OB DATES 1 9 7 8	MEO IO		If yee, sp			n, Puerlo	IN? (Specify Ye Rican, etc.)	e or No—	Black	Ameri k, White, e	tc.	ın,
G	ts. DECEDENT'S EDI (Specify only highest grad				USUAL O		ON ast of working		16	b. KIND OF BU	SINESS/IN	DUSTRY			
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MP	12th		C.	L. <i>P</i>	dju	stei				Coll		on (co.		
	t7. FATHER'S NAME (First, Middle, Last) Clem Franklin									Middle, Malder E. Pe	,				
BE	t9e. INFORMANT'S NAME (Type/Print)		100	- BAAN IN	2 4 DDDDC0	0 (0)				mber, City or Toy					
2	Clarice Maso	n								le Hi			2074	8	
	20a. METHOD OF DISPOSITION		20b PLACE	ANDDATE	OF DISPO	STIONYN	made me	eter	V DA	TE 20c. LC	CATION -	City or To	wn, State		
	4 Donation 5 Other (Specify)	noval from State	— Che	matory or	other place)	Nat	tion	a l l	0/3	0/95	Chel	ten	ham,	ME).
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE A 22. NAME AND ADDRESS OF FACILITY AUSTIN ROYSTER FUNERAL HOME														
	Jeny C	C. Cle	Hu	>						N.W.				010)
	23. PART I. Enter the diseases, or	complications th	at caused the da	ath. Do	not enta	r tha mo	da of dyl	ing, suci	h as ca	rdiac or resp	iratory a	rrest,		proxima	
	IMMEDIATE CAUSE (Final											erval Bo set and			
	disease or condition resulting in death) a. MULTIPLE INJURIES														
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CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											-			
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ERI	resulting in death) LAST	d													
	PART II. Other algnificant condition	na contributing to	o death but not r	eaulting	In the u	nderlyln	g causa s	givan in	Part I.	24a. WAS AF		24b	. WERE AU		
PHYSICIAN: MEDICAL										PERFO			COMPLET	E PRIDR	
MED							/			AA			1 YES		NO
ä	DID TOBACCO USE CON	TRIBUTE TO CA	AUSE OF DEA	TH Y	ES 🗆	NO []	UNC	ERTAI	N \square						
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DE	OTHE										
IYS	X XyES 2 ☐ NO 27. MANNER OF DEATH	1 Inpatient 2	☐ ER/Outpatient 3		4 □ Nu	raing Hon		esidence		ner (Specify)		DWAY		AST	1 100 100
	1 Netural 5 Pending		Day, Year)	342	JURY	WC	JURY AT ORK? YES 2	VNO		ESCRIBE HOW			Mu	-	195
ВУ	2 X Accident Investigation 3 Suicide 8 Could not be	28e. PLACE	OF INJURY — At ho					N HO	<u> </u>	CATION (Street					EV
TED	4 Homicide B Could not be determined	building	Rope Du						. Cit	y or Town, State)				W
E	290. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of			red at the	time data	and place	end due				-	act 10		C/
COMPLET	(Check only one) 2 MEDICAL EXAMIN												e) end mar	iner as s	tated.
	29b. SIGNATURE AND TITLE OF PERTIFI	ER DO O					29c. LICI	ENSE NUR	MBER		29d. DA	TE SIGNED	(Month, D	lay, Year)	
) BE	Morphie (An	2 Yould					0.	C.M	1.E			CT.			5
T0	30. NAME AND ADDRESS OF PERSON W Margarita Kore		USE OF DEATH (ITE	Pen	e, Print) n St	ree	t, I	Balt	imo	ore, N	lary	land	21	201	
	31. DATE FILED (Month, Day, Year) OCT 3 0 199	5 Salva	AN'S SIGNATURE	arke	3										

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

r t r m

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	negis inan			CERTIF	ICALE	UF	DEALL		REG. NO.			
	į. ,	1. DECEDENT'S NAME (First, Middle, La.	JOHN F	RAZIE	R				MONTE	of OEATH		YEAR 95	3. TIME OF DEATH
	1	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH			PLACE (State or Foreign
Pla		579-20-1241-A			73 YRS.	MONTHS	DAYS	HOURS MIN. (Month, Day, Year) 08/06/22					ningtonDC
3 should	~	9a. FACILITY NAME (If not institution, give						OR LOCATION OF D	EATH			NTY OF DE	
6,	СТОВ	5824 Puckum				Rho	ode	sdale			Do	rche	ester
- S	LU II	10s. STATE 10b, COU			10c. CIT	Y. TOWN O	R LOCAT	TION					10d. INSIDE CITY
nit. Pag	DIR.	2	rchester			Dhadaala				LIMITS? 1 YES 2 NO			
physician. burial-transit permit. Pages 1,	ERAL	5824 Puckum	Road			109. CITIZEN OF WH 21659 United							
physiciar burial-tra	FUN	11. MARITAL STATUS 1 X Never Married 2 Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	2 NO If yes, specify Cuban, Maxican			in, Puerto F		or No-	Black	- American Indian, White, atc.	
ding the	B	3 Widowed 4 Divorced		AN ON DAILS		_ '	_ 123	ZX NO Specii	у		- 1	эрисп	% Black
use as	9	15. DECEDENT'S E (Specify only highest gr		18a.	DECEOENT'S	USUAL OC	CUPATIO	ON set of working	16b.	KIND OF BUS	SINESS/INC	USTRY	
the hospital or detached for u once.	PLET	Elementary/Secondary (0-12) College (1-4 or 5+)			Disab	e retired.)	Juling Inc	st or working		N	/ A		
tach	COMPL	17. FATHER'S NAME (First, Middle, Last)			_	18. MOTHER'S NAME (First, Middle, Maiden Surname)							
at o	D III		John Fra	zier				Unkn		modre, marden	Surrieme)		
should should	œ	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a	nd Number or Rural		er City or Town	n State 7in	Codel	
be retained be 5 should a notified	2	Betty Gregg						n Rd.,					21659
e 6 may be ector, page must be		1 Burial 2 X Cremation 3 Ramoval from State cemetery, c				OATE OF DISPOSITION (Name of y or other place) OATE OATE							
Page al dire		21. SIGNATURE OF FUNERAL SERVICE	mbrid	dge Crematory 25 Cambridge, MD 22. NAME AND ADDRESS OF FACILITY									
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burlat-tran or removal. medical examiner must be notified at once.		Framptom-Hawkins-Eskow Funeral Home PO Bx 43, Federalsburg, MD 21632											
d in by the or removal medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
		ahock, or heart failure. List only one cause on each line. Interval Between Onset and Death											
within 24 upletely fill cremation, vent, the		disease or condition resulting in death)										11 hour	
rted within 24 ho completely filled rial, cremation, or c event, the m			PUE TO	(OR AS A CON	SEQUENCE O	F): '			0		- 12	1	(6
and o buy	CERTIFICATION	Sequentially list conditions, if any, leading to Immediate b. Hole Trusted Cardina Grant PAS DUE TO TOR AS A CONSEQUENCE OF):									YEAO.		
he death certificate be the attending physician Mental Hygiene prior to njury, or other traun	SA	cause. Entar UNDERLYING						ļ	- /	1	+1		
rtifica ig phy jiene	Ė	CAUSE (Disease or injury that initiated eventa	OUE TO	(OR AS A CON	SEOUENCE O	F):							
th ce endir	E	resulting in death) LAST											
e dea he att Menta jury,		PART II. Other aignificant condit	ona contributing to	death but no	ot requiting	in the un	darivin	a causa aluan in	Don't I	24a. WAS AN	ALETONOV	400	WERE AUTOPSY FINDINGS
that the sed by the sed by the sed by the sed anny in	EDICAL			douter but the	or reading	or tre, un	derlylli	y cause given in	rant I.	PERFOR		240.	MAILABLE PRIOR TO COMPLETION OF CAUSE
igned ealth rs ar										1 TYES 2	□ NO		OF DEATH?
sen s of H	Σ	DID TODA CCO HICE COA											1 TYES 2 NO
law baras boopt.	SICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	IIKIBUTE TO CA					UNCERTAI	ΝЦ				
The	ᅙ	EXAMINER?	HOSPITAL:		LACE OF OEAT	OTHER	t:						
CIAN ertific the S	¥	1 VES 2 DNO	1 Inpatient 2 I		_			e 5 (Rasidence					
PHYS this c with	РНҮ	1 Natural 3 Pending	(Month, D		28b. TIM	URY		PRK?	28d. OES	CRIBE HOW II	NJURY OC	CURED	
After Jeath ma	à	2 Accident Investigatio	28a PLACE O	F INJURY — At	home term	Mraat tacto		YES 2 NO	204 1 00	TION (Course		0	- I North
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior b IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traur	ETED	3 Suicide 6 Could not i	bullding,	atc. (Specify)	nome, tarm,	tarm, street_tactory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				outa Number,			
DIRE DIRE Hours	_	29a. CERTIFIER 1 CERTIFYING PH	YSICIAN: To the best of	my knowledge,	death occurr	ed at the tie	me, data	and place, and due	to the cau	se(s) and man	ner an stat	ed.	
SPITAL IERAL in 72	OMP												and manner as stated.
FUN with	0	296. SIGNATURE AND PITE OF GERTIN						29c. LICENSE NUI				E SIGNED	(Fronth, Day, War)
APOF	H	14/1/ 1 0 1A 1). (1 144/15 1 10/22/95										22/95	
F F Z ₹	유	DE NAME AND ADDRESS OF PERSON	HO COMPLETED CAUS	IR OF DEATH (//		161-			4	MY
		LOGK Na	/ -	MINGO			=1	FEDERA	1LSB	486,	MD	DI	632
		31. DATE FILED WAS 10-12-15 19	95 Julien	EPROVINI	hardall								

JRE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR REG. NO.										
Ĭ	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	ATE OF DEATH 3. TIME OF DEATH				
	GEORGIANA	н.	(In yrs. last birthday)	RTH	OCT. 24 DAY 1995 /D:00					
	4. SOCIAL SECURITY NUMBER 151-20-0201 9e. FACILITY NAME (If not institution, give s	1928 C	THPLACE (State or Foreign nity) ALTFORNTA							
DIRECTOR	27465 SS.ISLAN			TRAPPE	DEATH	9c. COUNTY OF	ALBOT			
JEC.	10e. STATE 10b. COUNT	Y	19c. CITY, T	OWN OR LOCATION			10d. INSIDE CITY			
AL DI	MARYLAND 10e. STREET AND NUMBER	TALBOT		TRAPPE		10g. CITIZEN OF WHAT COU				
IER/	27465 S.S. ISI	AND CREEK	ROAD	21673	3	USA				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 NO	13. WAS DECENDENT OF HIS If yea, specify Cuban, Mex 1 YES 2 NO Spe	Ican, Puarto Rican, etc.)	RIGIN? (Specify Yes or No — 14. RACE — American				
	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S USI	lat coordination			WHITE			
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during most of working	166. KIND OF BU	SINESS/INDUSTRY				
4PL	12	4	HOUSE	WIFE		OWN HO	ME			
CO	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	NAME (First, Middle, Malden	Surname)				
BE	DOUGLAS L. H 19a. INFORMANT'S NAME (Type/Print)	OOKER			LDRED ELA					
2	ROGERS FIRTH			C C TCTANT			DDE MD			
	20a. METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of Disposition City of Town State									
	1 Donation 5 Other (Specify)	oval from State	ALISBURY	CREMATORY	10-25 SAI	ISBURY, MD				
	21. SIGNATURE OF FUNERAL SERVICE LIC	CEMBEE			FACILITY					
	>11/ En Weu	Marie M	CHST	200 S. HAR			ON . MD			
	IMMEDIATE CAUSE (Finel	e. DUE TO (OR AS A	sch line.	enter the mode of dying, a		iratory srrest,	Approximate Interval Between Onset and Death			
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.									
PHYSICIAN: MEDICAL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 VES 2 NO 1 VES 2 NO 1 OF DE									
ä	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES	NO UNCERTA	JN 🗆		1 TES 2 NO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (Check only one)						
IYS	1 YES 2 NO	1 - Inpetient 2 - ER/Outp	etlent 3 DOA 4	Nursing Home: 5 Residence						
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW	NJURY OCCURED				
BÝ	2 Accident Investigation 3 Suicide Could not be	28s. PLACE OF INJURY	- At home, farm, stree		281. LOCATION (Street	and Number or Rum	Route Number			
TED	4 Homicide 8 Could not be determined	building, etc. (Spec	sify)	,	City or Town, State,	Transcor or Trans	rode rumos,			
COMPLET				the time, data and place, and d my opinion, death occured at t			(a) and manner as stated.			
BE C	296 SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE N		6 (Month, Day, Year)				
TO B	1/ Klein A V	front		D0244	4	101	25KG			
-				DUTCHMAN'S		STON,	MD 21601			
	31. DATE FILED (Month, Day, Yber) OCT 25 1995 Jahn Standall									

Immed # 16a, 11/2/95, MRS, allegary Co.

1 - STATE REGISTRAR	STATE OF MAR			IT OF HE				HENE			
1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEA	TH			3. TIME OF DEATH
ELDEN		FUENTI	FUENTE				OCTOBER	3 O	1.0	YEAR	4:15 P M
4. SOCIAL SECURITY NUMBER 5. SEX 6. AG		NGE (In yrs. last birthde	y) IF UND	F UNDER 1 YEAR IF UNDER 24 HRS.		7. DATE OF BIRTH			7 0	PLACE (State or Foreign	
216-30-2069	11X M 2 🗆 F	62 yrs	MONTHS.	DAYS F	HOURS	MIN.	July" 20	193	3	Mar	yland
9a. FACILITY NAME (If not institution, give	street and number)		9b. CIT	Y, TOWN OR	LOCATIO	ON OF DE	ATH		9c. COU	NTY OF DE	EATH
MEMORIAL HOSPITA	MEMORIAL HOSPITAL & MEDICAL CENTER		CIL	CIMPEDIAND							
RESIDENCE OF DECEDENT				CUMBERLAND ALLEGANY							
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LO					TOO, INDIDE OFF					10d. INSIDE CITY LIMITS?	
Maryland Allegany Lonaconing 1 □ ves 2½ No											
100. STREET AND NUMBER 15 Gills Hill 21539 109. CITIZEN OF WHAT C							HAT COUNTRY?				
11. MARITAL STATUS	12. WAS DECEDENT EV		13	. WAS DECEN	NDENT O	F HISPAN	IC ORIGIN? (Spec	Ify Yee o	r No-	14. RACE	- American Indian, , White, atc.
1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 X YES 2 NO FYES GIVE WAR OR DATES. KOTEAN CONTILCT				If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:				IC.)	so-White		
15. DECEDENT'S EDU (Specify only highest grade		16e. DECEDENT	of words done	during most	of wordin		16b. KIND (F BUSIN	ESS/INC	USTRY	
Elementary/Secondary (0-12) College (1-4 or 5+)			kind of work done during most of working NOT us prired.) DE-Brower Center				Mill				
17. FATHER'S NAME (First, Middle, Last) Joseph Anthony Fuente 18. MOTHER'S NAME (First, Middle, Midd											
190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Juanita R. Fuente 15 Gills Hill, Lonaconing, Md. 21539											
20e. METHOD OF DISPOSITION		20b. PLACE AND DAT	TE OF DISPO	SITION (Name	9 01		DATE 20	C. LOCA	TION —	City or Tov	wn. State
1 September 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		Laurel H	or other place	emete	ry N	Nov.	3,1995 N	losc	ow N	Mills	Md.
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22	. NAME AND	ADDRES	S OF FAC	CILITY				
Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539											
23. PART i. Enter the diseeses or ahock, or heart failure.	complications that cau List only one ceuse of	used the deeth. De on each line.	o not ante	r the mode	of dyle	ng, auch	as cerdiac or	reapira	tory arr	rest,	Approximete interval Between
IMMEDIATE CAUSE (Fine)	. Squamous	0011 000	or o	f tho	1.,,,		th Live	~ 0	n đ		Onset and Death
resulting in death)	DUE TO (OR	AS A CONSEQUENCE	OF):	1 the	Lun		din Meta				4 Months
Sequentially list conditions,	b	AS A CONSEQUENCE				Sr		Sta	212.		
if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (ON	NO A CONSCOUENCE	OF):								
CAUSE (Disease or injury thet initieted events	DUE TO (OR	AS A CONSEQUENCE	OF):								
resulting in death) LAST											
PART II. Other significent condition	a contributing to dee	th but not reaultin	g in the u	inderlying c	euse g	iven in I	Part i. 24a. W	AS AN AU			WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
Chronic Obstruc	tive Lung	<u>Disease.</u>						ES 2 [COMPLETION OF CAUSE
Achoetogic								1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER?											
1 TYES 2 NO	1 Inpatient 2 ER/	Outpatient 3 DOA	OTHE 4 Nu		5 🗆 Res	sidence (6 Other (Specify	1)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJU (Month, Day, Ye		IME OF INJURY M	28c. INJUR WORK 1 YES	?	NO	28d. DESCRIBE	ILNI WO	URY OCC	URED	
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datermined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)				oute Number,						
a numeros date/mined											
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner ea stated. MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) end manner ea stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)											
Mark Das				D 35481						ER 31,1995	
MARK SAGIN M.D., MEMORIAL HOSPITAL, CUMBERLAND, MD 21502											
MARK SAGIN M.D.,	MEMORIAL H	OSPITAL,	CUMBI	ERLAND), M	D 2	1502				
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 0.9 1905											
NOV 02 1995 Julia dander hardall											

TO BE COMPLETED BY FUNERAL DIRECTOR

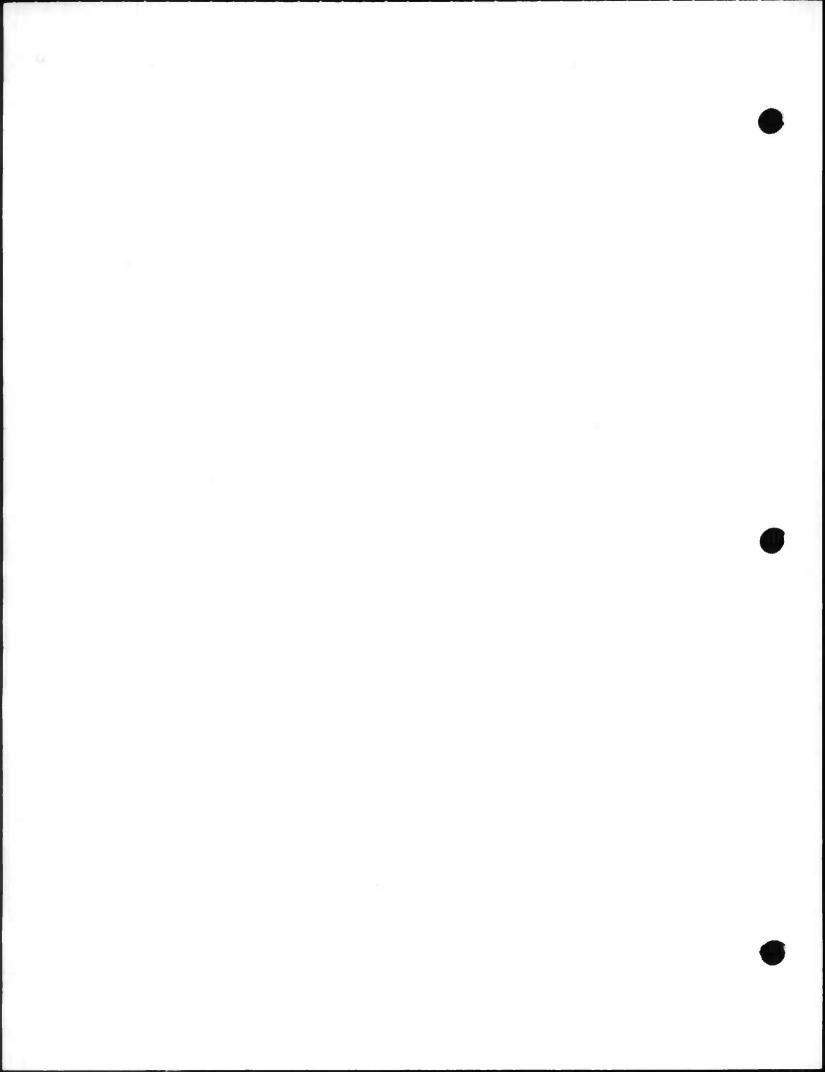
DIVISION OF VITAL RECORDS, P.O. DOX OOLOGY.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt, or Health and Mental Hyghen prior to burial, cremation, or removal.

The following the notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



BALTIMORE, MARYLAND 21215-0020

ITEMS: 23 PART I, 27, PER MEO FILM G-730 12/13/95 t.t

	1 - FOR STATE OF MA	ARYLAND / DEPARTM CERTIFICA	ENT OF HEALTH AND	MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last) ANTHONY LEE FRI	END		2. DATE OF DEATH MONTH DAY NOVEMBER 0	3. TIME OF DEATH 2 1995 8:02 A					
æ	4. SOCIAL SECURITY NUMBER 217-19-6688 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL	7 YRS. MON	UNDER 1 YEAR IF UNDER 24 HRS. THS DAYE HOURE MIN. CITY, TOWN OR LOCATION OF DI	ATH 9c. C	8. BIRTHPLACE (State or Foreign 8 West Virginia OUNTY OF DEATH LEGANY					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		WH OR LOCATION		10d. INSIDE CITY LIMITS?					
COMPLETED BY FUNERAL DI	Maryland Garrett 100. STREET AND NUMBER		Mt. Lake Par		1 YES 2 NO CITIZEN OF WHAT COUNTRY?					
		EVER IN U.S. ARMED] YES 2 X NO R OR DATES	21550 13. WAS DECENDENT OF HISPAIN (1984, specify Cuban, Maxicular) 1 YES 2 NO Specification (1984)	NIC ORIGIN? (Specify Yea or No- in, Puerto Ricen, etc.)	USA 14. RACE American Indian, Black, White, alc. Specify: White					
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use reti	done during most of working ired.)	166. KIND OF BUSINESS/	/INDUSTRY					
OM	2nd 17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NA	ME (First, Middle, Malden Surname							
BE C		iend		nifer Lynn						
9	19a. INFORMANT'S NAME (Type/Print)		PRESS (Street and Number or Rural	the second second second						
	Jennifer L. Sweitzer 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremelton 3 Removal from State 4 Donatton 5 Other (Specify)	20b. PLACE AND DATE OF DI	SPOSITION (Name of	1	— City or Town, Slata					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	taylor s.	22. NAME AND ADDRESS OF FA Stewart Funer	ситу al Home	kland, MD 21550					
	resulting in death) a	o on each line. DISORDER								
CERTIFICATION	Sequantially list conditions, If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL CE	PART II. Other significant conditions contributing to c	Part I. 24a. WAS AN AUTOP: PERFORMED? 1 YES 2 NO	AMAILABLE PRIOR TO							
PHYSICIAN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER:									
BY PHYS	27. MANNER OF DEATH 1 XXNetural 5 Pending 2 Accident Investigation	Nursing Home 5 Realdence 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED							
	3 Suicida 8 Could not be determined 28e. PLACE OF building, a	t, factory, offica	281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)							
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, daeth occurred at the time, data and place, and dua to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of axaminerion and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.									
TO BE C	296. BIONATURE AND TITLE OF CERTIFIER	AN	O . C . M	.E ▶ì	DATE SIGNED (Morith, Day, Year) NOVEMBER 03, 199					
-	MARIO GOLVE JR	and the second s	nn Street,	Baltimore, 1	Maryland 21201					
	31. DATE PICE NOV 0 9 1995	S STONATURE NO SOLLA								

BALTIMORE, MARYLAND 21215-0020

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH VOISEY GRAHAM 18.00 95 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 049-48-1246 49 1 M 2 X F HOURS YRS. Nov. 9, 1945 Jamaica Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Prince Frederick Calvert County Nursing Center Calvert RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY Maryland Calvert Lusby 1 YES 2 X NO permit. 10e, STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit o burial, cremation, or removal. 11542 Tomahawk Trail West 20657 Jamaica Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS OCCEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexicen, Puerto Rican, etc.)
1 YES ZXXNO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ВУ Specify: Black 3 Widowed 4XX Divorced ETED 16a. OECEDENT'S USUAL OCCUPATION

"Take kind of work done during most of working 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Nurse's Aide Nursing 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname Leuwing 7 McLean BE Enead Chambers notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 P.O. Box 1459 Glenis Graham Lexington Park, MD 20653 pe 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Metropolitan Crematory 10/27/95 4 Donation 5 Other (Specify) Alexandria, VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY Sewell Funeral Home hours after death. koncer 1451 Dares Beach Rd. Prince Frederick, MD medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. Liet only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Finel Onset and Death** the disease or condition_ Deficiency Syndrome OUB TO (OR AS A CONSCOURCE OF): resulting in death) traumatic event, executed CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to certificate has been signed by the attending physician the State Dept. of Health and Mental Hygiene prior to If any, leading to immediata the death certificate be cause. Enter UNDERLYING other t CAUSE (Disease or Injury **OUE TO (OR AS A CONSEQUENCE OF):** that initiated events resulting in death) LAST 6 PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS any AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2XXNO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN I PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) The Item EXAMINER? HOSPITAL: Nursing Nome 5 Residence 6 Other (Specify) 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 6 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) with to 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED is marked, 1 Natural 5 Pending 1 YES 2 NO After t В 2 Accident Investigation 26e. PLACE OF INJURY - At home, farm, street, tactory, office 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be DIRECTOR: / 4 Nomicide 28 8 29a. CERTIFIER 1 VERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. FUNERAL F = 2 ___ MEDICAL_EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 296. SIGHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) B ▶ 10 1043306 95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sylvia Batong, M.D. Lusby, MD 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. About death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

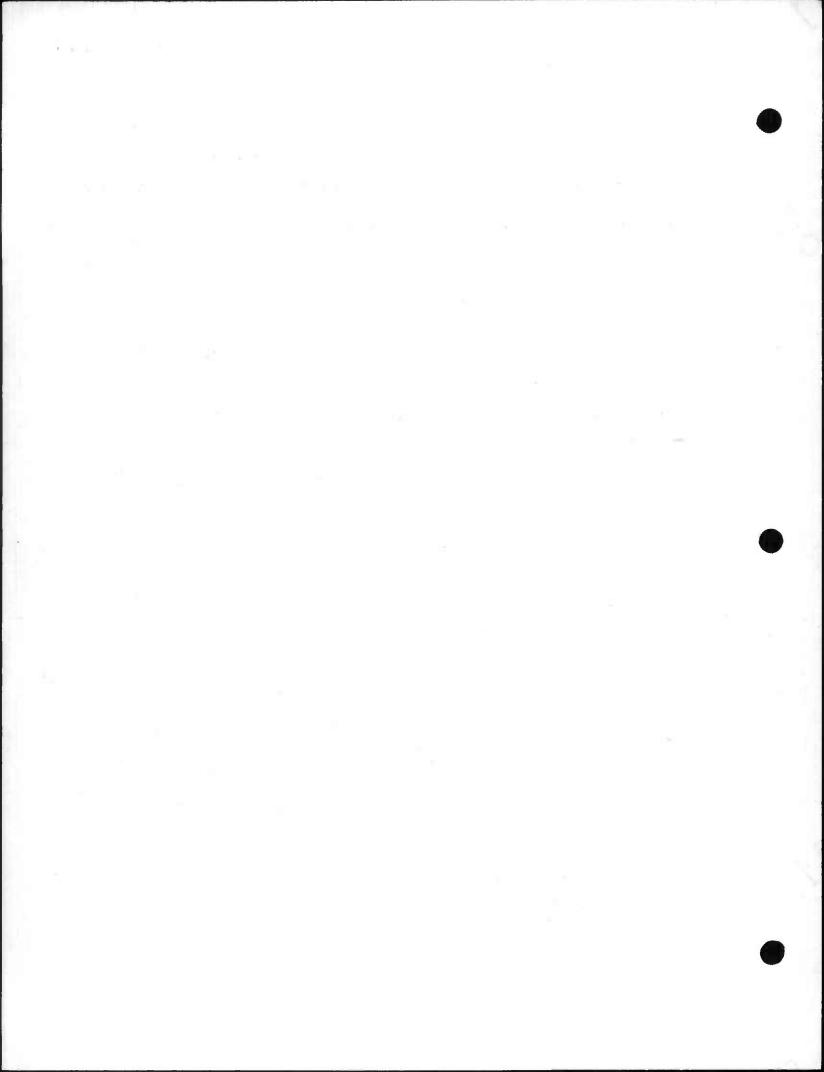
	Item20a,g-729,	11-29-9	5,perf.h.,	dk						95	3	4771
	1 - FOR STATE REGISTRAR		STATE OF MA			TMENT OF	HEALTH AND		HYGIEN	E		
	James Leo Gold: 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In)				ng t birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF MONTH	nber		995	5. TIME OF DEATH 6p. M LACE (State or Foreign
	578-22-5943		X M 2 □ F	71	YRS.	MONTHS DAYS	HOURS MIN.	June	June 19,1924 Mary			and
TOR	9a. FACILITY NAME (If not institute 1100 Owens R	Road, #			9b. CITY, TOWN OR LOCATION OF DEATH OXON Hill OXON ETT. OXON Hill OXON Hill							
DIRECTOR	Maryland 10h	Princ	ce George	e's		on Hill	TION			10d. INSIDE CITY		
FUNERAL	100. STREET AND NUMBER 1100 Owens R	toad #	112			11	20745					at country? States
B	11. MARITAL STATUS 1 Never Merried 2 Malert 3 Wildowed 4 Divorced	ried	FORCES? 1X	YES 2 N		If yes, a	CENDENT OF HISP/ pecify Cuban, Maxic 3 2 2 NO Spec	en, Puerto Ric	Specify Yea en, etc.)	or No—	14. RACE - Black, Specify: Bla	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)			(Gi life.	(Give kind of work done during most of working life. Do NOT use retired.)				usiness/industry ton Inn Resturant			
BE CON	17. FATHER'S NAME (First, Middle, Lest) James Edward Goldring 16. MOTHER'S NAME (First, Middle, Melden Surname) Frma C. Lewis											
TO E	19e. INFORMANT'S NAME (Type/Print) Mary A. Goldring				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Owens Road #112 , Oxon Hill, Md 20745							
	20s. METHOD OF DISPOSITION 20 Burlel 2 K Cremation 3 4 Donation 5 Other (Special Control of Control	c/fy)				_	ember 10	-	Clin	ton,	Maryl	and
22. NAME AND ADDRESS OF FACILITY @ Funeral Home, Inc 66.3 Old Alexandria Ferry Road, Clinton, Md 2						Inc 6633 con, Md 2073						
	23. PAPT I. Enter the disease shock, or heart IMMEDIATE CAUSE (Final disease or condition resulting in death)	ses, or com failure. List a	Cance:	on each line	ne pr	ostate	ode of dying, su			ratory sri	rest,	Approximats Interval Batween Onset and Death
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
IL CERT	resulting in deeth) LAST d PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS											
PHYSICIAN: MEDICAL	PERFORMED? 1 YES 2 NO PERFORMED? AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO							OMPLETION OF CAUSE OF DEATH?				
YSICIAN	25. WAS CASE REFERRED TO ME EXAMINER? X YES 2 NO	DICAL	OSPITAL:	26. PLAC	OF DEAT	H (Check only one) OTHER: 4 Nursing Hor	ne 5X Residence		pecify)			
B	2 Suitald	tigation	28a. PLACE OF III	Year)	28b. TIMI INJ	URY W	URY AT ORK? YES 2 NO	28d. DESCR			or Rural Rou	in Niirehar
LETED	4 Homicide detari	mined	building, ato	. (Specify)		- I - I - I - I - I - I - I - I - I - I		City or 1	own, State)	- Ivalinosi	U THE FIOL	no estimon,

November 4, 29c. LICENSE NUMBER 1995

D21230

P Augusto Camp Springs, MD 20748

M.D. 5009 Rayburg REGISTRAR'S SIGNATURE Julia Davidson Revolut 1995



TO BE COMPLETED BY FUNERAL DIRECTOR

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DIVISION OF	AL OR ATTENDING PHYSICIAN: The law
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR			C	ERTIFI	CATE OF	DEATH	F	REG. NO.		
1. DECEDENT'S NAME (First,	, Middle, Last)					100	2. DATE OF MONTH	DEATH DAY	YEAR	3. TIME OF DEATH
SADIE YOUN	IG GREEI	R						er 23		11:51 P M
4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (In yrs. le		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, De		8. BIRT	THPLACE (State or Foreign
214-32-866	58	1 M 2 X F	59	YRS.	MONTHS DAYS	HOURS MIN.		4 1930	- -	ome, MD
9a. FACILITY NAME (If not in	stitution, give stre	et and number)			9b. CITY, TOWN	OR LOCATION OF DE	EATH		9c. COUNTY OF	
Washington		y Hospit	:a1		Hage	rstown, l	Maryla	nd	Washin	gton, County
10a. STATE	10b. COUNTY			toc. CITY	TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
Maryland	Princ	ce Georg	ges		Temple	Hills, 1	Maryla	nd		1 YES 2 NO
10e. STREET AND NUMBER			:			1. ZIP CODE			10g. CITIZEN OF	WHAT COUNTRY?
1883 Ivers	on Stre	eet				20748	8		Unite	d States
11. MARITAL STATUS			T EVER IN U.S. A			CENDENT OF HISPAI			No- 14. RA	CE — American Indian, ick, Whita, atc.
1 Never Married 2 Amerried 2 Amerried 5 Never Married 6 Never Married 7 Never Married 7 Never Married 8 Never Married 8 Never Married 8 Never Married 9 Never										
15. DEC	EDENT'S EDUCA	ATION	18a. D	ECEDENT'S	USUAL OCCUPAT	ON	16b. KI	ND OF BUSIN	IESS/INDUSTRY	
Elementary/Secondary (I	ly highest grade co	College (1-4 or 5	- lin	a. Do NOT use	ork done during m retired.)	ost of working				
12				De	omestic			Pr	ivate	
17. FATHER'S NAME (First, A	fiddle, Last)					18. MOTHER'S NA	AME (First, Mide	tle, Malden Su	rname)	
James Gre	er					Bessi	ie Eli:	zabetł	Dougla	as
19a. INFORMANT'S NAME (Type/Print)		11	9b. MAILING	ADDRESS (Street	and Number or Rural				
Elaine Bro	wn			2353	Iverson	Street 1	Temple	Hills	. MD 20	0748
20a. METHOD OF DISPOSIT			20b. PLACE	ANDDATEO	F DISPOSITION (A		DATE		TION — City or	
1 Donation 5 □ Other		val from Stata	cemetery, cr	remetory or oth	Memoria	al Park	10/30	T	andove	r. MD
21. SIGNATURE OF FUNERA	L SERVICE LICE	NSEE	N.	1 -	22. NAME A	ND ADDRESS OF FA	CILITY			
D/1/1/1/	75	2 ~ (1	Ka		xander S				
MAY !	5	40168	40 7	001						le, MD 20747
23. PART I. Enter the dehock, or h			use on each lin		ot enter the m	ode of dying, aud	ch aa cardlad	c or reapira	tory arreat,	Approximate Intervel Between
IMMEDIATE CAUSE (FI		in only one	311 00011 III.							Onset and Death
diseese or condition resulting in death)	→ .	Муос	ardial I	nfarc	tion					Sudden
Totaling in double,			OR AS A CONSI		,					
	b.	Нуро	tensive	Arthr	osclero	tic Hear	t Dise	ase		Yes
Sequentially list condit if any, leading to imme	diete	DUE TO	OR AS A CONSI	EOUENCE OF):					
cause. Enter UNDERLY CAUSE (Disease or Inju										
that initiated eventa resulting in death) LAS		DUE TO	OR AS A CONSI	EOUENCE OF):					
recutting in death) CAS	d.	•								
PART II. Other algorific	ant conditions	contributing to	deeth but not	resulting i	n the underlyle	ng ceuse given in	Part I. 24	Ia. WAS AN A	UTOPSY 24	4b. WERE AUTOPSY FINDINGS
								PERFORM		AVAILABLE PRIOR TO COMPLETION OF CAUSE
							— ¹	TYES 25	X NO	OF DEATH?
DID TODACCO I	ICE COLITE	IDLUTE TO C	NUCE OF DE	ATLL VE		T UNICEDIAL				1 TES 2 NO
DID TOBACCO U		IBUIE IO C			H (Check only one		N L			
25. WAS CASE REFERRED TEXAMINER?		HOSPITAL:			OTHER:					
1 YES 2 NO			ER/Outpatient			me 5 Rasidence	_			
27. MANNER OF DEATH 1 X Natural 5	Pending		Day, Year)		URY W	JURY AT	28d. DESCR	IIBE HOW IN.	JURY OCCURED	
2 Accident	Investigation	N/		N/		YES 2 NO		N/A		
3 Suicide 8 4 Homicide	Could not be		OF INJURY — At I I, atc. (Specify)		treet, lactory, off	ca	City or	Town, State)	d Number or Rura	Il Houte Number,
				N/A			<u> </u>	1	A/A	
Check only	TIFYING PHYSIC	SAN: To the beat of	of my knowledge, o	death occurre	d at the time, da	la and placa, and du-	e to the cause	(a) and menn	er as stated.	
one) 2 X MED	DICAL EXAMINER	t: On the basis of	examination and/o	r investigatio	n, In my opinion,	death occured at the	e time, data an	d place, and	dua to the cause	e(a) and manner as stated.
296. SIGNATURE AND TITY	E OF CEROTFIER	1	,			29c. LICENSE NU	JMBER ,	,	29d. DATE SIGN	ED (Month, Day, Year)
HIV	10	edes				DIL	2 66		DO	24.1945
30. NAME AND ADDRESS	F PERSON WHO	COMPLETED CA	USE OF DEATH-(IT	EM 27) (Type,	Print)				<u> </u>	Style -
HIN	I. W	EEKS	581	ON	ORTHE	ERN P	AN H	AGEA	STON	am,
OCT 3		James 1	AUGUAN VA	at it					(



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF I			IYGIENE REG. NO.			
		MARIA 5. SEX 6. AGE	GREENLI	2. DATE OF DEATH 10-25-				10:45 ^M		
OR	4. SOCIAL SECURITY NUMBER 577-32-4032	1 M 2 F 90 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 03-12-19								
		9e. FACILITY NAME (If not institution, give street end number) 1012 Elsa Avenue					1101	9c. COUNTY OF DEATH Prince George's		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCA	TION			16d. INSIDE CITY			
		ce George	's Se	eat Ple					LIMITS?	
RAL	100. STREET AND NUMBER 6313 Field St		101. ZIP CODE 20743					F WHAT COUNTRY?		
BY FUNERAL	11. MARITAL STATUS 1 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, OIVE WAR OR I	2 X NO	If yes, s	CENDENT OF HISPA Decity Cuben, Mexico 3 2 NO Specific	en, Puerto Rice		U.S.A. se or No- 14. RACE — American Indian, Black, White, etc. Specify: Black		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT u	USUAL OCCUPATI work done during m se retired.)	ost of working		or Busines			
OM	17. FATHER'S NAME (First, Middle, Last)	4	Denoc	72 2040	16. MOTHER'S NA	AME (First, Midd	lle, Meiden Sum	ame)		
BE C	Charles Asb	ary Green			Annie		ıglas			
5	190. INFORMANT'S NAME (Type/Print) Brenda Arnett	/Niece			end Number or Rural				MD 20785	
	20b. PLACE AND DATE of DISPOSITION 20b. PLACE AND DATE of DISPOSITION Name of 1 10 30 20b. DCATION — City or Town, State 2 Cremetion 3 Removal from State 2 Cremetion 5 Other (Specify)									
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PERFORMED? 1 Tyes 2 No						24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	GROTE TO CAUSE O	28. PLACE OF DEA			иП				
YSIC	EXAMINER? 1 X YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Ou			me 5 Residence	_				
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	26e. DATE OF INJURY (Month, Day, Year)		JURY W	JURY AT ORK? YES 2 NO	28d. DESCR	ULNI WOH BBIS	BE HOW INJURY OCCURED		
TED BY	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	atreet, fectory, off	y, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLET	[Check only	CIAN: To the best of my kno							se(s) end manner ee stated.	
TO BE	29b, SIGNATURE AND TITLE OF CERTIFIES	one no	DEATH (ITEM 27) (Top	e Print)	BO3	111	1	10.	26-25	
	Gary W. Jon.	es MD. 11	305 PM	tsea D	Belt	wille	Nd 2	3070	5-1757	
	31. DATE FILES (Month, Day, Year) OCT 311995	32 REGISTMAR'S SIG	A Paradia							

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TO BE COMPLETED BY FUNERAL DIRECTOR

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician,	ALL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the State Dect. of Health and Mental Hybiene prior to burial, cremation, or removal.	item 23 shows any injury, or other trau
TO THE HOSPITAL OR ATTENDING PHYSI	TO THE FUNERAL DIRECTOR: After this certifing the filed within 72 hours after death with the	IMPORTANT: If Item 28 is ma

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR	1 . STATE STATE STATE OF MARTILAND / DEPARTMENT OF REALITY AND MENTAL TITGLENE								
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TI							. TIME OF DEATH		
CASSIF DE	ELORES	GL	ASG	OW	МОНТН	er 2		YEAR	Linn P .
		In yrs. last birthday) #	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE 0	OF BIRTH		BIRTHPL	ACE (State or Foreign
577-32-5088	□ M 2 💢 F	67 YRS. MON	THE DAYS	HOURS MIN.		6, 19		Country)	Virginia
9s. FACILITY NAME (If not institution, give street		<u> </u>	CITY, TOWN C	R LOCATION OF DE		0, 19	9c. COUNT	_	
134 Old Enterpris	e Road			arlboro			_	-	eorge's
RESIDENCE OF DECEDENT	e Road	10	pper n	alibolo			7 7 7 7 7 7	~ 00	20.90
10s. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION				1	Dd. INSIDE CITY LIMITS?
Maryland Prince	Maryland Prince George's Upper				r Marlboro				YES 2 X NO
10e. STREET AND NUMBER			101	ZIP CODE			10g. CITIZE	N OF WH	AT COUNTRY?
134 Old Enterpris	e Road		2	0772			U.S.A	Α.	
11. MARITAL STATUS 12	. WAS DECEDENT EVER IN		13. WAS OEC	ENDENT OF HISPAN	NIC ORIGIN	? (Specify Yes	or No- 1	4. RACE -	- American Indian,
1 Never Married 2 Married	FORCES? 1 YES			2 NO Specific		lican, etc.)		Specify:	White, stc.
3 Widowed 4 Divorced									White
15, OECEDENT'S EDUCATI (Specify only highest grade con		16a. DECEDENT'S USU (Give kind of work			16b.	KIND OF BUS	INESS/INDU	STRY	
Elementary/Secondary (0-12)	college (1-4 or 5+)	life. Do NOT use rel	tired.)	•	i				
12		Homemaker			Ov.	vn Home	е		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, A	fiddle, Malden	Sumame)		
Walter F. Eckard				Margie	Moat	s			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	DRESS (Street s	nd Number or Rural	Route Numb	er, City or Town	n, State, Zip C	Code)	
William E. Glasgo	w, Jr.	2545 Ar	bor Co	urt, Dav	idsor	nville	, Mary	yland	i
20s. METHOD OF DISPOSITION		PLACE AND DATE OF D		me of	DATE	20c. LO	CATION - CI	ty or Town	, Stats
1 Burisi 2 X Cremation 3 Removal 4 Donation 5 Other (Specify)	from State Cen	etery, crematory or other etropolita	_{plece)} n Crem.	atory 11	/01/91	5 410	vandr	ia V	Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	or oported.	22. NAME AN	ID ADDRESS OF FA	CILITY				
1.31				is Gasch					
W.D. Jer	ser								MD 20781
23. PART i. Enter the diseases, or com ahock, or heart fallure. Liet			enter the mo	de of dying, suc	ch aa card	llac or respi	ratory srres	st,	Approximate Interval Between
IMMEDIATE CAUSE (Finei	,								Onaet and Death
disease or condition resulting in death)	CARCANO DUE TO (OR AS A	MA RIG	UT PY	RIFORM	1511	1415			2/42
	DUE TO (OR AS A	CONSEQUENCE OF):	-015	1011 0 1011					710
		END-S	MAGE						
Sequantially list conditions, if any, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE OF):							
CAUSE (Disease or injury									3 1
that initieted eventa	DUE TO (OR AS A	CONSEQUENCE OF):							
resulting in death) LAST									
PART II. Other significent conditions of	antifluides to death h		ha a da da da da	and the re-	De d I			1	
		ut not resulting in to	ne underlying	g ceuee given in	Part I.	24a. WAS AN PERFOR		A	PERE AUTOPSY FINDINGS MAILABLE PRIOR TO
EXSANGUINATION)				— I	1 YES 2	NO		OMPLETION OF CAUSE OF DEATH?
			1-2					1	☐ YES 2 ☐ NO
DID TOBACCO USE CONTRIB	SUTE TO CAUSE C	F DEATH YES	Z NO [UNCERTAI	N 🗆				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEATH (
M	☐ Inpatient 2 ☐ ER/Out		THER: Nursing Hom	e 5 KRasidence	6 🗆 Othe	r (Specify)			
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		URY AT	28d. DES	CRIBE HOW I	NJURY OCCU	JRED	
1 Natural 5 Pending 2 Accident Investigation	(YES 2 NO					
3 Suicide 8 Could not be	26s. PLACE OF INJURY	- At home, farm, atree	et, factory, offic	0		ATION (Street 1	and Number of	r Rural Acc	ite Number,
4 Homicide determined	building, atc. (Specify)								
29s. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my brown	ledge death courses	t the time date	and place and dis	to the ar-	anda) and are-	one se stat-	4	
(Check only one) 2 MEDICAL EXAMINER:									and manner as stated
	Course or gamment	Stores investigation, It	, opinion, c			one prace, sn			
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	-	29d. DATE	SIGNED (A	Month, Day, Year)
July MC MD				072	12:)	100	toke	RC1, 1995
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	nt)	0 -	7			4.5	
J. BERGER MD #	205, 7720	ATH (ITEM 27) (Type, Pril W/SCON)	SINA	re, Bel	hesa	da 1	1d.	208	14
31. DATE FILED (Month, Day, Year) OCT 3 0 1995	32. FEGISTRAN'S SIGN	ATURP							

PHYSICIAN: MEDICAL CERTIFICATION

BY

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-c4 hours after death. Page 6 may be retained by the hospital or attending physician.
10 HE FUNEMAL UNIECHUR: After this certinicate has been signed by the affending physician and completely miled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

95 34775 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF OEATH 3. TIME OF DEATH Laura L. Gebbia 1995 October 7:50 Рм 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign HOURS 1 🗌 M 2 😿 F 100-22-5155 68 1927 Connecticut July 15, 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR 2520 Sollers Wharf Road Lusby Calvert RESIDENCE OF DECEDENT 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Seabrook 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9402 Sheridan Street 20706 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried If yes, specify Cuben, Mexicon, Puerto Rican, etc.) TYES 2 1 NO BY Specify. 3 Widowed 4 Divorced Specify: White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. OFCEDENT'S EDUCATION 186. KIND OF BUSINESS/INQUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Food Manager Restaurant 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Antonio Innocenti BE Marianna Gelli 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sam J. Gebbia 9402 Sheridan Street, Seabrook, Maryland 20706 20a. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 1 Donation 5 Other (Specify) OATE Fort Lincoln Cemetery 10/31/95 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Entar the diseases, or complications that ceused the death. Do not entar the mode of dying, such as cerdisc or respiratory erreat, Approximate shock, or heart failure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition METASMINE OAT OFLE CARCINOGA resulting in death) QUE TO (OR AS A CONSEQUENCE OF Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury

that initiated events resulting in death) LAST	d.
PART ii. Other significant	conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2 19-110

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 TO NO

DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEATH	YES 🖾 N	40 🗆	UNCERTAIN
WAS CASE REFERRED TO MEDICAL		26. PLACE OF	DEATH (Check of	only one)	
EXAMINER?	HOSPITAL .		07115		

HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 Nu	R: reing Home 5 Aesidence	6 Other (Specify)
28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	26d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFIER	1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place,	and thus to the cause(s) and manner as stated
one)		one due to the cades(s) and mainler as stated

MEDICAL EXAMINER: On the basis of ex	xamination end/or investigation, in my opinion, d	leath occured at the time, date end place, e	nd due to the ceuse(s) end manner ee stated.
196. SIGNATURE AND OTTLE OF CERTIFIER		29c. LICENSE NUMBER	29d. DATE SIGNEO (Month, Day, Year)

John H S	myel my		726358
IO. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print)	1000

8 Could not be

1 YES 2 100

27. MANNER OF DEATH

1 | Natural

2 Accident

3 Suicide

29e. CE

4 Homicide

Julia Develor hardel

OCT-29

01, . . .

Search 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICHE

	1 - STATE REGISTRAR	C	ERTIF	ICATE	OF DEA	TH		EG. NO.	_					
Á	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	HTAS			3. TIME OF DE	ATH		
	BLANCA L.	GRAJED	Α				OCT.	28,	1995	YEAR	4:00 1	A. M		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. Is	st birthday)	IF UNDER 1		R 24 HRS.	7. DATE OF B	HRTHS /	29/3	a. BIRTH	PLACE (State or	Foreign		
	218-08-2638 1 D M 2 🖾 F	64	YRS.	MONTHS	MYS HOURS	MIN.	9 - S	OI	6717	REU	", GUAT	EMALA		
	9s. FACILITY NAME (If not institution, give street and number)			9b. CITY, T	OWN OR LOCAT	ON OF DE	ATH		9c. COU	NTY OF D	EATH			
CTOR	710 ROEDER ROAD APT. 10	04		SIL	VER SPI	RINGS			MON	TGOM	ERY			
DIRECTOR	MD. MONTGOMERY			Y, TOWN OR LVER	LOCATION SPRING						10d. INSIDE CIT LIMITS? 1 X YES 2			
	10e. STREET AND NUMBER				10f. ZIP COD	E			10g. CITI	ZEN OF W	WHAT COUNTRY?			
FUNERAL	710 ROEDER ROAD APT. 10	004			2091	LO			CEN	TRAT.	AMERIC	.Δ		
5	FORDERS	NT EVER IN U.S. AF	RMED		S DECENDENT						- American Inc.			
ВУ		WAR OR DATES	NO		es, specify Cubi			, etc.)		Speci				
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			USUAL OCC			16b. KIN	D OF BUS	INESS/IND					
4	Elementary/Secondary (0-12) College (1-4 or 5	His	Do NOT us	work done dur se retired.)	ing most of world	ng								
COMPLETED	2nd 0	(CHILD	-CARE			CH	ILD-	CARE					
8	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle							
BE	JOSE M. GRAJEDA						ILDE E							
임	19a. INFORMANT'S NAME (Type/Print)		b. MAILING	ADDRESS (S	treet and Number	or Rural A	oute Number, C	ity or Town	, State, Zip	Code)	O MD C	0070		
	MIRIAM GRAJEDA (DAUGHTER					APT.					G, MD 2	20910		
	2(a, METHOD OF DISPOSITION 1 Durisi 2 Cremation 3 Removal from Stata 4 Donation 8 Johner (Specify)			NATTO	NAL CEN	1.	11/1		REL,		wn, State YLAND			
	21. SIGNATURE OF UNERAL SERVICE LICENSEE			22, NA	ME AND ADORE	SS OF FAC	TARRAT	. SFE	VICE					
	> Capel Stock	M972			O. BOX						0			
	23. PART VEnter the diseases, or complications th	at caused the de	eath. Do n					-			Approxim	nata		
	IMMEDIATE CAUSE (Final	use on each line	a. 						,		Interval I Onset ar	Between		
ļ	disease or condition				CAR	CINO	MA				245	ars		
_	DUE TO	O (OR AS A CONSE	OUENCE OF	F):										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	O (OR AS A CONSE	OUENCE OF	F):							-			
S	cause. Enter UNDERLYING										İ			
Ē	and militated events	OR AS A CONSE	OUENCE OF	F):							+			
E	resulting in death) LAST													
	PART II. Other algnificent conditions contributing to	death but not	reaulting i	n the unde	riving cause	niven in P	Part 24a	WAS AN	umnev	245	WERE AUTOPSY	Enionios		
MEDICAL					in ing cause			PERFOR	WED?	240.	AVAILABLE PRIOR	OT F		
ED							_ 1 [YES 2	∑ NO		OF DEATH?			
	DID TOBACCO USE CONTRIBUTE TO CA	AUSE OF DEA	TH YE	SIN		EDTAIN					1 YES 2	NO		
A	25. WAS CASE REFERRED TO MEDICAL		JSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one)											
Sic	EXAMINER? 1 YES 2 NO 1 Inpetient 2	☐ ER/Outpetient 3	DOA	OTHER:	Home 5	seldence 8	Other (Spe	nc/fu)						
PHYSICIAN:	27. MANNER OF DEATH 28s. DATE O		28b. TIMI	E OF 28	c. INJURY AT		28d. DESCRIB		JURY OCC	URED				
ВУР	1 Netural 5 Pending 2 Accident Investigation	Day, rear)	INJ	M M	WORK?] NO						- 1		
ED B	3 Suicide 8 Could not be 28s. PLACE	OF INJURY At he	ome, form, s	treet, factory	offics		281. LOCATION	(Street si	nd Number	or Rural A	oute Number,			
쁘	3 Suicide 8 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, offics building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, offics City or Town, State)													
ist 1	29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the heat of my knowledge death against the line of the heat of my knowledge death against the line of the heat of my knowledge death against the line of the heat of my knowledge death against the line of the heat of my knowledge death against the line of the heat of my knowledge death against the line of the li													
7	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of	f my knowledgs, de	CERTIFIER (Check only one) CERTIFIER (Check only one) CERTIFIER (Check only one) CERTIFIER (Check only one) CERTIFIER (Check only one) MEDICAL EXAMINER: On the besis of sxamination and/or investigation, in my opinion, death occurred at the time, data and due to the cause(a) and manner as stated.											
OMPLE	(Check only CERTIFYING PHYSICIAN: To the best of						lme, data and				and manner sa	stated.		
E COMPLET	(Check only CERTIFYING PHYSICIAN: To the best of				lon, death occur	red at the ti	BER		due to the	e cause(a)				
BE	(Check only one) 2 MEDICAL EXAMINER: On the besis of				lon, death occur	red at the ti	BER		due to the	e csuse(a) SIGNED	(Month, Day, Year,			
ш	(Check only 2 MEDICAL EXAMINER: On the best of 29b. SIGNATURE AND TITLE OF CERTIFIER	examination and/or	investigation	n, in my opin	29c. LICI	red at the ti	BER	place, and	due to the	e csuse(a) SIGNED				
BE	(Check only 1 DENTIFYING PHYSICIAN: To the best of complete of the best of the	examination and/or	M 27) (Type,	n, in my opin	29c. LICI	red at the ti	BER	place, and	due to the	e csuse(a) SIGNED	(Month, Day, Year,			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

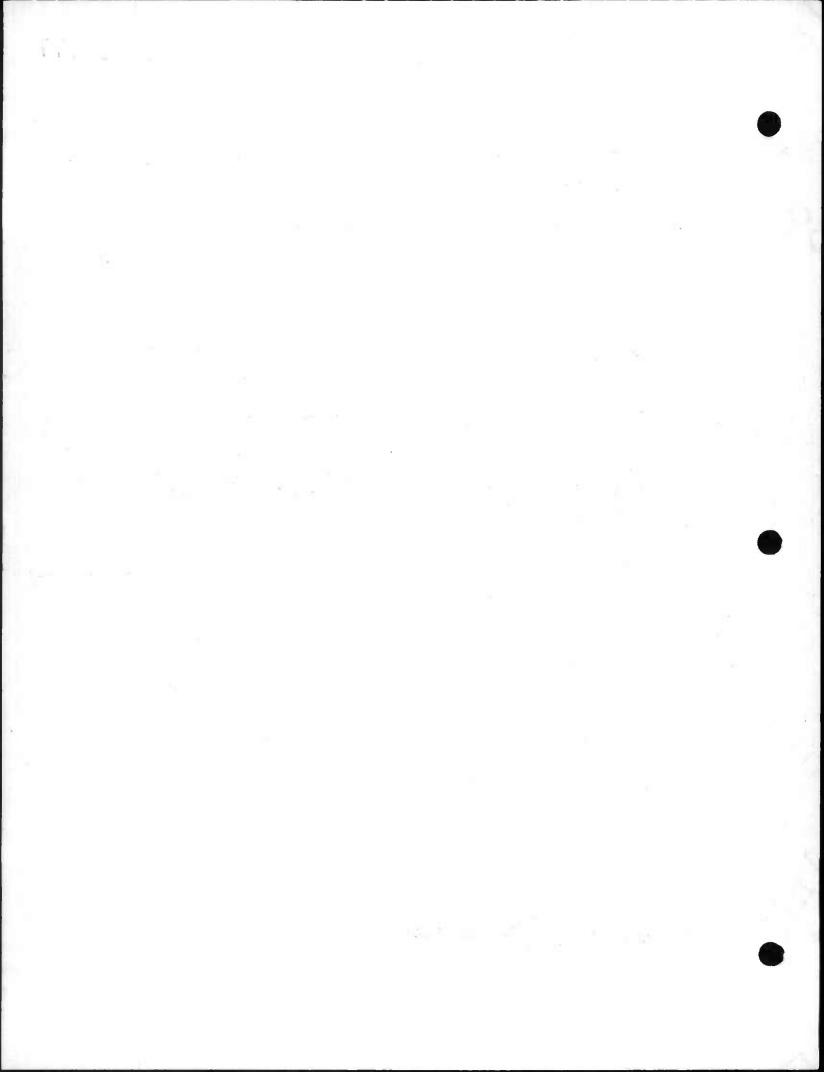
BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withman hours after death. Page 6 may be retained by the hospital or attending physician.	ler death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should / 1 / 1 / 2 / 3 should / 1 / 3 / 3 / 3 / 3 / 3 / 3 / 3 / 3 / 3
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	al examiner must be notified at once.

	1 - FOR STATE REGISTRAR		STATE OF MARY		EPARTMEI RTIFICAT			MEN	NTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, I	Middle, Last)			_				DATE OF DEATH			3. TIME OF DEATH
N	MAR	4	A.		(7K	All	ES		OCI 2		995	gian PM
12	4. SOCIAL SECURITY NUMBER		. SEX 6. AG	E (In yrs. lest b		ER 1 YEAR	IF UNDER 24 HRS.		DATE OF BIRTH (Month, Day, Year)			PLACE (State or Foreign
- 1	577-60-4174		☐ M 2 🗷 F	88	YRS. MONTH	DAYS	HOURS MM.		arch 15,	1907		ARYLAND
	9a. FACILITY NAME (If not inst				9b. CI		R LOCATION OF D	PEATH		9c. COU	NTY OF D	
0	Washington		1st Hospit	al		Tako	ma Park			Mont	gome	ry County
EG	RESIDENCE OF DECE	10b. COUNTY		T	10c. CITY, TOW	OR LOCAT	ION	_				10d. INSIDE CITY
DIRECTOR	Maryland	Princ	e Georges	_			lary1and					LIMITS? 1- YES 2 NO
	10e. STREET AND NUMBER					101	ZIP CODE			10g. CIT	IZEN OF W	VHAT COUNTRY?
FUNERAL	6030 Sargean	nt Road	#3108				20782			Uni	ted	States
5	11. MARITAL STATUS		2. WAS DECEDENT EVE	R IN U.S. ARME	D 1				RIGIN? (Specify Yes	or No-	14. RACE	— American Indian,
BY	1 Never Married 2 x N 3 Widowed 4 Divorce		FORCES? 1 YE				2 NO Speci		erto Rican, etc.)		Speci	white, etc.
												Diack
Щ	(Specify only i	DENT'S EDUCAT	mpleted)	(Give	DENT'S USUAL kind of work dor NOT use retired	e during mo			16b. KIND OF BUS	SINESS/INC	DUSTRY	
2	Elementary/Secondary (0-1	(2)	College (1-4 or 5+)		ouse Ke	,			Feder	al G	over	nment
COMPLETED	8 17. FATHER'S NAME (First, Mid	idle, Last)					16. MOTHER'S N.	AME /F	First, Middle, Malden	Sumamal		
	Benjamin Bu	ıtler					Calli			Gurriarray		
BE	19a. INFORMANT'S NAME (Typ			19b. I	AAILINO ADDRE	SS (Street a	nd Number or Rural	Route	Number, City or Town	n, State, Zip	Code)	
2	Homer Grave	es		60)30 Sar	geant	Rd #31	80	Chillum,	MD	2078	2
	20s METHOD OF DISPOSITIO	N 3 🗆 Ramoval	from State		DATE OF DISP		ne of		OATE 20c. LO	CATION —	City or To	wn, State
	4 Donation 3 Donation (S	Specify)			and Na		1	1	1/4	Laur	e1,	MD
	21. SIGNATURE OF FUNERAL	SERVICE LICEN	SEE / J	(2		ander S		ope Fune	ral i	Ното	c
	(Ver). U	400 11.	,					-			, MD 20747
	23. PART I. Enter the dis	eeses, or con	pilcatione they cause on	ed the deet	n. Do not ent	er the mo	te of dying, suc	ch aa	cerdiec or reepi	ratory sri	rest,	Approximete
- 1	IMMEDIATE CAUSE (Fine		and the street									interval Between Onset and Deeth
	diseese or condition resulting in death)		CONC	7237	IVE	HE	ART	i	-A(UU	RE		2-3 mg
	Service of Street				ENCE OF):	- A .	1 110		6610	071		2
N N	Sequentially list conditions, b. REHAL FAILURE (HIZOKIC 24).											
F	if any, leading to immedicause. Enter UNDERLYIN											, -
RTIFICATION	CAUSE (Disease or Injury that initiated events		DUE TO OR AS	A CONSEQUE	ENCE OF):	101	1.					-
E	resulting in deeth) LAST	d	AIZT	CEPLI	05 cl	1=120	2-154	id	EART	10	C12. 6-	
S	PART II. Other significent	t conditions o									_	
8	JAMES III. Other algumeets	Conditione	ontributing to desti	i but not ree	uiting in the	underiying	ceuse given in	1 Part	i. 24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC									1 YES 2	NO		OF DEATH?
	DID TOBACCO US	E CONTRIB	LITE TO CALIEF	OF DEATH	VEC 🗆	NO E	LINICEDIA		, l '			1 TYES 2 NO
HYSICIAN:	25. WAS CASE REFERRED TO		OTE TO CAUSE		OF DEATH (Chec		UNCERIAI	N L				
	EXAMINER?	H	OSPITAL:		ОТН	ER:						
H H	27. MANNER OF DEATH	17	28a. DATE OF INJUR	Y 2	8b. TIME OF	28c. INJ	5 Residence	_	. DESCRIBE HOW II	JURY OC	CURED	
ВУР	1 Netural 5 Pe	ending vestigation	(Monte, Day, Year)	INJURY	WO	RK7 ES 2 NO					
	2 Catalda	ould not be	28a. PLACE OF INJU building, atc. (S)	RY — At home.	farm, street, fa	ictory, office		28t.	LOCATION (Street a	nd Number	or Rural R	loute Number,
LED		Marmined	Sulfaring, arc. (5)	oocay)					City or Town, State)			
7	29a. CERTIFIER (Check only	YING PHYSICIAI	N: To the bast of my kn	owledge, death	occurred at the	time, data	and place, and due	a to the	e cause(a) and man	ner aa stat	ed.	
COMPLET												and manner as stated.
n O	29b. SIONATURE AND TITLE O	F CERTIFIER		J			29c. LICENSE NU	MBER		29d. DAT	E SIGNEO	(Morgth, Day, Year)
0	A-il	M	. mel	vta	am		D 27.	36	-6	1	0/30	· 93-
=	30. NAME AND ADDRESS OF	PERSON WHO C	OMPLETEO CAUSE OF							1.	ή,	1 140
	ARVING	V. WE	7 11 1	13 Ca	alti	nere	tue 4	. 5	ing U	1/23	e 14	~ k 20740
- 11	NOV 02	400F	A PEGISTRAR'S SI	GNATINE	48							
	NOV 02	1995	CHANA AURUST	OL LONG	4							1





STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last)

YEAR

3. TIME OF DEATH

REG NO 2. DATE OF OEATH DAY

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Ε. 1995 7:35 OCTOBER 28, Α WILLIAM 4. SOCIAL SECURITY NUMBER 5 SEY 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 577-98-9185 1 XM 2 F 25 Nov.16,1969 Pennsylvania permit. Pages 1, 2, 3 should 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 3904 ALTON STREET PRINCE GEORGES CAPITOL HEIGHTS 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MD 1 X YES 2 NO Prince George's Oxon Hill 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE use as the burial-transit 1500 Southview Drive # 204 20745 U.S.A. after death. Page 6 may be retained by the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 YES 2 XNO Specify: Specify: В 3 Widowed 4 Divorced Black. ETED 16a. DECEDENT'S USUAL OCCUPATION 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th Student N/A once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at William Morris Helen Gross notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Helen Lett North 63rd St. Philadelphia, PA. 19151 pe 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 ☐ Fremation 3 ☐ Removet from State DATE 20c. LOCATION — City or Town, State 11-2-9 Beltsville, MD 20b. PLACE AND DATE OF DISPOSITION (Name of must Chesapeake Crematory 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home filled in by the filon, or removal. 7474 Landover Rd. Landover MD 20785 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or reapiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death IMMEDIATE CAUSE (Final the cremation, disease or condition Multiple Gunshot Wounds completely resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING physician certificate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evanta attending resulting in death) LAST 6 death the atten Mental F PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY Health and PERFORMED? WAILABLE PRIOR TO any COMPLETION OF CAUSE 1 PYES 2 NO shows a 1 VES 2 NO has been : Dept. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\text{V}}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: AND 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Hem State certificate OTHER:
4 □ Nursing Home 5 X Residence 6 □ Other (Specify) HOSPITAL: 1 X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA OR ATTENDING PHYSICIAN: 0 this certifi 280. DATE OF INJURY F (Month, Ray, Year) 28b. TIME OF 27. MANNER OF DEATH 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, subject shot 1 Natural 5 Pending 1 YES 2 NO 10/27/95 DIRECTOR: After the hours after death v ВУ Investigation 2230 2 Accident 261. LOCATION (Street and Number or Rural Route Number City or Town, State) 3 90 4 4 fon St. 3 Suicide
4 Homicide 28s. PLACE OF INJURY - At home, farm, street, factory, office .09 8 Could not be COMPLETED 28 building Fol Healts, item 29s. CERTIFIER
(Check only one)

27 MEDICAL EXAMINER: On the basis of examination and/or investigation. In my online, death occurred at the time, data and place, and due to the cause(a) and menner as atsted. TO THE FUNERAL C THE filed within 72 h IMPORTANT: If II HOSPITAL 2X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B 표 Christo ans OCTOBER 28, 1995 enns O.C.M.E. PPE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month) 32 REGISTRIAR'S SIGNATURE 021995 OHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

GROSS

. Make and the

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND N	MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)	Wilson H	Reuben	Gale		2. DATE OF DEATH		3. TIME OF DEATH
0	Wilson Gale.	WIISON I	xeaben	Gare		MONTH 00		8:49 A.M.M
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	A BIRTI	HPLACE (State or Foreign
	578-60-3186	1 🛣 M 2 □ F 49	YRS.	HITHS DAYS	HOURS MIN.	October 12		Shington, D.C.
œ	90. FACILITY NAME (If not Institution, give str Prince Georges Go				R LOCATION OF DE LEVET1y	ATH	9c. COUNTY OF D	
DIRECTOR	RESIDENCE OF DECEDENT		-aı		leverty		Prince	Georges
EC	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ION			10d. INSIDE CITY
DIE		e Georges	H	illcres	t Height	S		1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 1903 Oakwood S	treet		101	20746		10g. CITIZEN OF United	
NE I	11. MARITAL STATUS	12. WAS DECEDENT, EVER IN	US ARMED	13 WAS DEC		IC ORIGIN? (Specify Yes		E — American Indian,
	1 Never Married 2 🔀 Married	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Maxicar	, Puerto Rican, etc.)	Blac	ck, White, etc.
ВУ	3 Widowed 4 Divorced	March 1970/0		71 TES	2 X NO Specify		Spec	Hy: DIACK
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	16a. DECEDENT'S US	UAL OCCUPATION	ON st of working		SINESS/INDUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	101.			eneral Se	
₹ D		years	Support S	Service			istration	1
8	17. FATHER'S NAME (First, Middle, Last) Wilson S	inclair	Gale		18. MOTNER'S NAM Gladv	AE (First, Middle, Malden S Mae		Т-11
B	19a. INFORMANT'S NAME (Type/Print)							Talley
2	Vivian Celestine 1	(wife) Bradley Gale	1903 Oa	akwood	Street, H	oute Number, City or Town	n, State, Zip Code) Heights , M	20746 Maryland
-	20a METNOD OF DISPOSITION 1/ LABuriel 2 Cremetion 3 Remo	206.1	PLACE AND DATE OF E	ISPOSITION (Na	me of	DATE 20c. LO	CATION — City or To	own, State
	4 Donation 5 Other (Specify)	real from State FOT	tery, crematory or other Lincoli	n Cemet	ery/Oct.	30,1995 Br	entwood.	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22. NAME AN	O ADDRESS OF FAC	Latney	s Funera	1 Home
	Theh Latre	4 97				Avenue, N. W		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A C	ch line.		da of dyling, auch	as cardiac or raapi	ratory arrest,	Approximata Interval Between Onset and Daath
CERTIFICATION	Sequantially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):					
AL C	PART II. Other algnificant conditions	contributing to death bu	t not rasulting in t	ha undariying	cause given in I			a. WERE AUTOPSY FINDINGS
	- Amy Thu	na -				PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC	0					_ ' ' ' ' '	Light NO	DF DEATN? 1 YES 2 NO
2	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES		UNCERTAIN			1 123 2 100
Ž	25. WAS CASE REFERRED TO MEDIGAL	2	6. PLACE OF DEATN (011021(1711)			
Sic		HOSPITAL: 1 Inpatient 2 ER/Outpet		THER: Nursing Nom	5 Residence	5 Other (Specify)		
높	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJ	JRY AT	28d. DESCRIBE NOW II	NJURY OCCURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation		_		ES_ 2 NO	-		
	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, atc. (Specifi	- At home, farm, stree	et, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Rural I	Route Number,
# 1	4 Homicide determined					-		
COMPLETED		CIAN: To the best of my knowled						
ខ្ច	MEDICAL EXAMINER	: On the basis of examination	and/or Investigation, I	n my opinion, d	eath occured at the t	ime, date and pleca, an	d due to the couse(s	i) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER	29d. DATE SIGNED	
၉	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	IN (ITEM 27) (Fine Or	me)	(۵(مد م		h (-, wa)	17
	Massoud Nemati, N				e 407;Te	mple Hills	,Marylan	id 20748
	31. DATE FILED (Month, Day, 221)	32 REGISTRAD'S SIGNAT	Madel					

. MIT E 75 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

	HEGISTHAH		CE	SECTION	CAIL	OF I	DEAL		REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)						_		2. DATE OF DEATH MONTH DA	W 1.4	YEAR	3. TIME OF DEATH
	Robert Lee Gri							\rightarrow	November	1, 1		2:46 P M
	4. SOCIAL SECURITY NUMBER 065-42-6029	5. SEX 1 📆 M 2 🗌 F	6. AGE (In yrs. lest	YRS.	MONTHS DA	_	HOURS		Teb. 6, 1	951	Counti	PLACE (State or Foreign ry) Cyland
i	9e. FACILITY NAME (If not institution, give str	21		+	9b. CITY, TO		1.001710				INTY OF D	,
or I									NIT!			
0	5812 Main Street				Que	ens	town	1		Qu	een A	Annes
EC	10e. STATE 10b. COUNTY			10c, CITY	, TOWH OR L	OCATIO	ON					10d. INSIDE CITY
DIRECTOR	7	Annes		Qu	eenst							1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 5812 Main Street						2165				SA	WHAT COUNTRY?
N.	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARI	MED	13 WAS				IC ORIGIN? (Specify Yes			E — American Indian.
	1 Never Merried 2 Merried		X YES 2 N		If ye	s, spec	Ify Cube	n, Mexicen	, Puerto Rican, etc.)		Blac	k, White, etc.
BY	3 Widowed 4 Divorced	IF TES, GIVE W	AH OH DATES		1	TES 2	ZEINO	Specify:			Spec	my: Diack
	15. DECEDENT'S EDUC	CATION	16e. DE	CEDENT'S	USUAL OCCU	PATION	٧		16b. KIND OF BUS	SINESS/IN	DUSTRY	
E	(Specify only highest grade Elementery/Secondery (0-12)	College (1-4 or 5+	Ma	Do NOT us	rork done durir e retired.)	ng most	of workin	19	United	She	11 F:	ish
COMPLETED	12th			borer					Seafoo	d Cor	mpany	у
0	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	HER'S NAM	ME (First, Middle, Malden	Surname)		
BE C	Carroll Griffin						Ka	atie	Griffin			
	19e. INFORMANT'S NAME (Type/Print)		191	. MAILINO	AOORESS (S	treet en	d Number	or Rural A	loute Number, City or Tow	n, State, Zi	ip Code)	
2	Lorraine Roberts	3		5812	Main	St,	Que	eenst	own, Md.	2165	8	
	20a, METHOD OF DISPOSITION 1	oval from State	20b. PLACE A		Vet.			ry	0ATE 20c. LO		ah, l	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NA	ME AND	ADDRE	SS OF FAC	h Funeral	Hom	6	
	Dem & E	Prince	2		1				687, Easto			1601
	23. PAH Enter the diseases, or c shock, or heart fallura. I				ot enter the	e mod	le of dyl	ing, such	as cardiac or reapl	ratory s	rreat,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final	List Only Olis Cau	ise on each mic									Onset and Death
	disease or condition			Al	20							241
	resolding in death)	OUE TO	(OR AS A CONSE	DUENCE OF	F):							C
z		b										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	(OR AS A CONSEC	DUENCE OF	F):							
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	C										
#	that initiated eventa resulting in death) LAST	OUE TO	(OR AS A CONSE	DUENCE OF	7):							
Ë	reading in death) Exer	d										
	PART II. Other algnificant condition	a contributing to	death but not r	esulting	n the unde	rlying	cause	given in			248	. WERE AUTOPSY FINDINGS
EDICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
		-			- 2					N. NO	-	OF OEATH? 1 YES 2 NO
Σ	DID TOBACCO USE CONTE	PIRLITE TO CA	LISE OF DEA	TH YE	SIN	77	LINC	FRTAIN			1	
AN	25. WAS CASE REFERRED TO MEDICAL	CIBOTE TO CA			TH (Check only		0110	LICITAL	1 44			
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:	ED/Outpatient 3	□ DOA	OTHER:	a Nama	c \$7.0	neldanna	6 Other (Specify)			
7	27. MANNER OF DEATH	28e. DATE OF		28b. TIM		Bc. INJU	_	percentoe	28d. DESCRIBE HOW	INJURY O	CCURED	
	1 Netural 5 Pending	(Month, D	Day, Year)	INJ	M M	WOF		□ NO				
BY	2 Accident Investigation 3 Suicide & Could not be		OF INJURY — At ho	me, ferm,	street, factory	, office			281. LOCATION (Street		er or Rural	Route Number,
윤	4 Homicide 6 Could not be determined	building,	etc. (Specify)						City or Town, State;)		
=	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	f my knowledge de	eth occum	ed at the time	date	end place	end due	to the cause(e) and me	nner ee al	ated.	
COMPLET	(Check only one) 2 MEDICAL EXAMINE	5 L - 2 - 10 -										e) end manner ee stated.
	29b. SIGNATURE AND TITUE OF CERTIFIE	0					200 110	ENSE NUM	4RED	294 D4	TE SIGNE	D (Month, Day, Year)
BE	A STATE OF LAND IN SECURITY	JAnn	N. W.)				-	.036	D	11/2	15
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAU	ISE OF DEATH (ITE	M 27) (Type	, Print)		•				1/36	"
	Jan S	Drove	2	801	0.1	m	wh	Om	u Ch	tu	MX	21619
	31. OATE FILEO (Month, Dey, Year) NOV 03 1995		AR'S SIGNATURE	all								7
	10.7.7	/ /	2 W. M.	A. A								

fing physician. the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR REGISTRAR	STATE OF MAR	YLAN	D / DEPAR	RTMEN	T OF H	EALTH .	AND M	IENTAL	HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest) Robert	K				6.	.) (/		MONTH	OF DEATH	AY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 222-16-1924 99. FACILITY NAME (If not institution, give str	5. SEX 6. A	70	s. lest birthday) YRS.	IF UNDER	DAYS	IF UNDER :	MIN.	7. DATE (Month	844 3 OF BIRTH (, Day, Year) 22,1	925	Count	ryland
TOR	PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO												
AL DIRECTOR	Maryland Wic	omico			y, town o	ar	ION				100 017	TZEN OF	10d. INSIDE CITY LIMITS? 1 YES 2 NO WHAT COUNTRY?
FUNERAL	302 Pennsylv							2187			Į	JSA	WINT COOKINIT
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR (ES 2	NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or If yee, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2/(3KNO Specify:							14. RACI Black Speci	- American Indian, k, White, etc.
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12) 1st	ATION completed) Cotlege (1-4 or 5+)	184		work done se retired.)	AL OCCUPATION 16b. KIND OF BUSH done during most of working fired.) Manufact							ompany
	17. FATHER'S NAME (First, Middle, Last) Herb Gordy 18. MOTHER'S NAME (First, Middle, Meiden Surname) Minnie Mae Callaway												
IO BE	190. INFORMANT'S NAME (Type/Print) Juanita Webster						nd Number o	or Rural Ad	ute Numb	elmar	n, State, Zij	p Code)	
	20e. METHOD OF DISPOSITION 1		20b. PL/ cemeters Capi	CEAND DATE	of bispos ther place) 'ema t	OTV	me of		DATE	20c. LO	DOVE	City or To	wn, State 19901
	21. SIGNATURE OF TYNERAL SERVICE LICE	Mucos			Be Do	name an innie	Smit De 19	s of fact th Fi	ıner.	al Hon	ne, P	.0.	691
CENTIFICATION	23. PART Enter the diseasea, or complicatione that ceused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):												
	PART II. Other eignificent conditions	contributing to dea	th but n	ot resulting	In the ur	nderlying	ceuea gl	ven in P	ert i.	24s. WAS AN PERFOR	RMED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO
THE SECTION.	DID TOBACCO USE CONTR	IBUTE TO CAUSI		EATH YE			UNCE	RTAIN					
2	1 YES 2 AO	HOSPITAL:	Outpatier				5 🗆 Resi	idence 8	□ Other	(Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED								CURED				
IED DI	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route City or Town, State)										loute Number,		
COUNT LE LES	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner as stated.												
0 BE 0	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF BRASON WHO TO THE TO THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE TOTAL OF THE T	gelië Ampleted chuse ch Pangeli	sto	<u> </u>	Print	10	PS J	J.C.	1070	D P.	DE COAT	e signed	(Month, Day, Mars)
	31. DATE FILED (Month, Day, Year)	John Stud		Cardall					0	/	-		13-/

16 a 2

Jeath. Page 6 may be retained by the ho	funeral director, page 5 should be detache	xaminer must be notified at once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 💅 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache has find within 70 hours after health with the State Dent of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE OF MARYLAND 1 - STATE REGISTRAR		IENT OF HEALT		NTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)				DATE OF DEATH	YEA	3. TIME OF DEATH				
1	JULIA CORNELIA	GAR	RETT			1995					
	4. SOCIAL SECURITY NUMBER - 5. SEX 6. AGE (In yrs.		UNDER 1 YEAR IF UN		DATE OF BIRTH (Month, Day, Year)	6. Bi	RTHPLACE (State or Foreign puntry)				
	220-03-3835 1 M 2 X F 75	YRS.	CITY, TOWN OR LOC	N	ov.12,19	919 MZ	ARYLAND				
DIRECTOR	MEMORIAL HOSPITAL		EASTON	ALLOW OF BEAUT		TALBOT					
EG	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c. CITY, TI	OWN OR LOCATION				10d. INSIDE CITY				
E I	MARYLAND TALBOT	E	ASTON			1 TYES 2 X NO					
	10e. STREET AND NUMBER		101. ZIP C	ODE		10g. CITIZEN OF WHAT COUNTRY?					
FUNERAL	29313 HEWORTH ROAD		2	1601		USA					
5	11. MARITAL STATUS 1 ☐ Never Merried 2 X Merried 12. WAS DECEDENT EVER IN U.S. FORCES? 1 ☐ YES X	ARMED	13. WAS DECENDEN	IT OF HISPANIC (Juben, Mexicen, P	ORIGIN? (Specify Yes ouerto Ricen, atc.)	or No — 14. F	RACE - American Indian, Black, White, etc.				
ВУ	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	27	1 🗆 YES 2 🗶	NO Specify:		S	Specify: WHTTE				
ED	15. DECEDENT'S EDUCATION 16s.	DECEDENT'S USI	UAL OCCUPATION		18b, KIND OF BUSI	NESS/INDUSTF	TY				
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during most of wi tired.)	orking							
립	12	HOUSE	WIFE		OWN	HOME					
COMPLET	17. FATHER'S NAME (First, Middle, Last)		18. N		(First, Middle, Maiden S	iurname)					
BE (GEORGE O. DULIN				E JONES						
5			ORESS (Street end Nur				Maria				
			HEWORTH DISPOSITION (Name of	RD.,		ATION City of					
			place CEME	TERY 1							
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADI	DRESS OF FACILI							
	JOHN R. MERCERON C	FSP			SON ST.	•					
	23. PART I. Enter the diseases, or complications that caused the shock, or heart failure. Liet only one cause on each if	death. Do not	enter the mode of	dying, such a	s cardiac or reapir	etory errest,	Approximeta interval Between				
	IMMEDIATE CAUSE (Final										
	recuiting in death) e. METASTATIO	C MELA	NOMIT				YEARS				
_	Sequentially list conditions . To. SMALL BOWL OBSTRUCTION										
CERTIFICATION	Sequentially liet conditions, If any, leeding to immediate										
CA	ceuse. Enter UNDERLYING			-							
E	that initileted events resulting in deeth) LAST	SEOUENCE OF):									
5	d						1				
AL	PART ii. Other algnificant conditions contributing to death but no			-	rt I. 24a. WAS AN /		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
5	UPPER GASTRUINTEST	TNAL	BLEZDIN	Ga	1 TES 24	240	COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MEDIC							1 TYES 2 NO				
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DI			NCERTAIN							
CZ	EXAMINER? HOSPITAL:		THER:								
14S	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 27. MANNER OF DEATH 28e. DATE OF INJURY	26b. TIME O	Nursing Home 5 DF 26c, INJURY A	- 1	Other (Specify) Bd. DESCRIBE HOW IN	LIURY OCCURE	'n				
	1 Natural 5 Pending (Month, Day, Year)	INJUR	Y WORK?	2 NO	BU. DESCRIBE NOW II	OOKI OCCORE					
В	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — All	t home, ferm, atre			Bf. LOCATION (Street a	nd Number or R	ural Route Number,				
딢	3 Suicide 8 Could not be determined Suicide Suic										
Ä	29e. CERTIFIER (Check only (Ch										
COMPLET	MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner ee stated.										
C	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year									
00	10/28/95 DO 10/28/95										
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TALIS	OT 5T						
	WILLIAM BREMER	MU) S	T MICHA	LS MI	121663						
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATUS OCT 3 1 1995	al-II									
	OCT 3 1 1995 Haba dimeliar is	W-G-G-M									

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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURS

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30. NAME AND ADDRESS OF PERSON

31. DATE FILED (Month, Day, Year)

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	law requires that the death certificate be executed within 24 hours after death, Pag
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95 34783 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OCT. SOPHIE GOLDIE 27,1995 9:00 AM w 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign IF UNDER 24 HRS. 1 🗆 M 2 😿 F 064-22-4182 NOV.6,1907 **NEW YORK** 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 29671 APPLE DRIVE CORDOVA TALBOT RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND TALBOT CORDOVA 1 YES 2 XNO FUNERAL 10a STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 29671 APPLE DRIVE 21625 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.) TO YES 2 XNO Specify: ΒY 3 Widowed 4 Divorced Specify: WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) 12 HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surnam 76 WILLIAM HERSH BE HENRIETTA NEWMAN notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JEANNE J. VAIL 29671 APPLE DRIVE, CORDOVA, MD 21625 99 200. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must 20e. METHOD OF DISPOSITION

1 Buriat 2 Cremation 3 Removal from State

4 Donation 8 Other (Specify) HOPE CEMETERY 10-31 WESTCHESTER CO.NY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. JOHN ERLERON CFS 200 S. HARRISON ST., EASTON. medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata ahock, or haert feliure. List only one cause on each line. **IMMEDIATE CAUSE (Final** Onset and Death the th May + Caucer disease or condition Lyvs reaulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ceuse. Entar UNDERLYING **CAUSE** (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 shows any injury, PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceues given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Неш Неш HOSPITAL: **EXAMINER?** OTHER: 1 YES 2 NO 1 | Inputient 2 | ER/Outputient 3 | DOA Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATN 28e. DATE OF INJURY 28d. DESCRIBE NOW INJURY OCCUREO 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 1 Natural 5 Pending Investigation м 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 3 Sulcide 8 Could not be COMPLETED 4 Nomicide 200 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. THE HOSPITAL (
THE FUNERAL D
filed within 72 ho 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(e) and manner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER

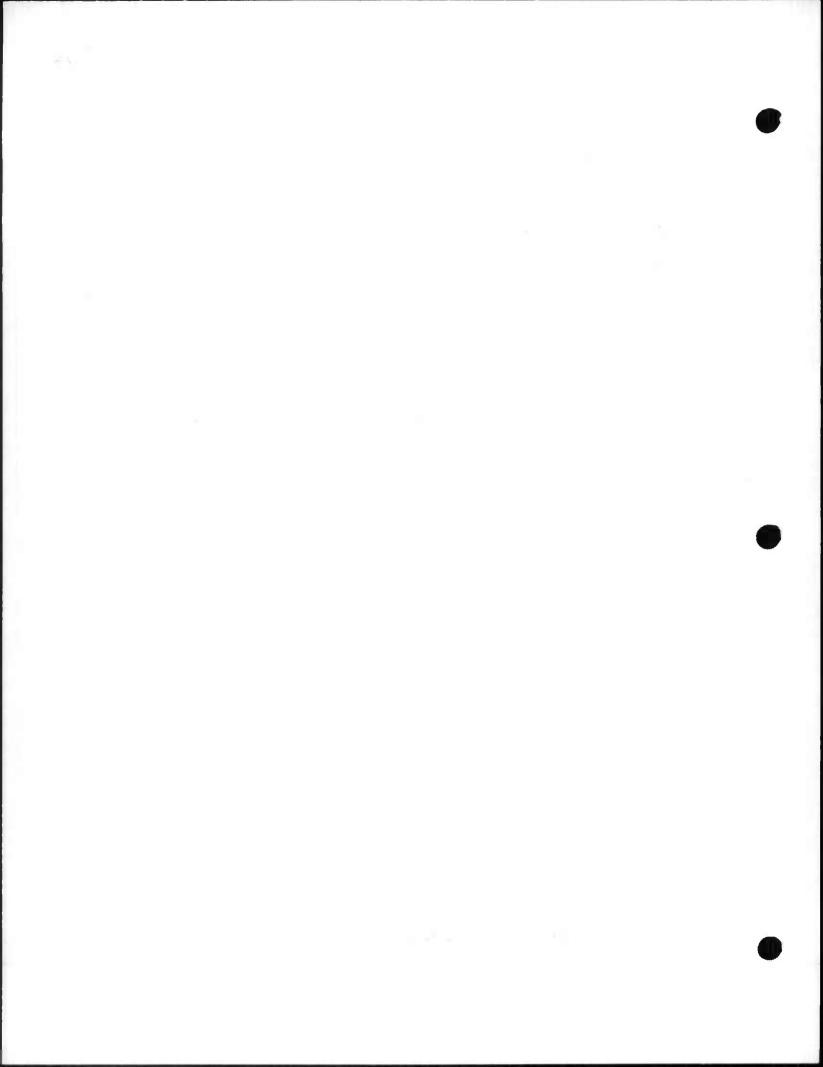
DAVID H.SMITH, N SDLICENSE NUMBER

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29d. DATE SIGNED (Month Day, Year)

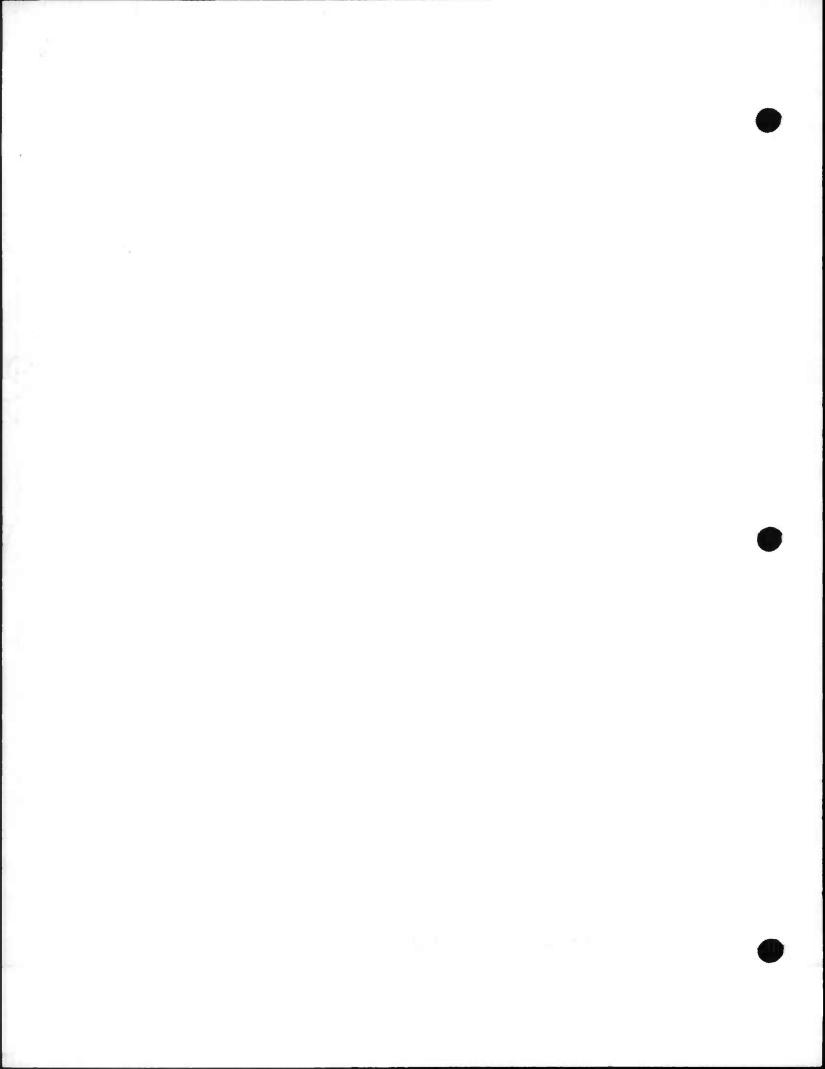
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		FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	IEALTH AND I	MENTAL HYGIEN				
		1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D		3. TIME OF DEATH		
,		Joseph	Gardner				Oct 24		5 1:20 A M		
		4. SOCIAL SECURITY NUMBER		yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	- 1	BIRTHPLACE (State or Foreign Country)		
pjn		164-16-6177 9e. FACILITY NAME (If not inelitation, give etr	1 X M 2 D F	90 YRS.			Nov. 13,				
2, 3 should	Œ	The Pines	eet end number)		· ·	OR LOCATION OF OR	ATH	9c. COUNTY			
1, 2,		RESIDENCE OF DECEDENT			£a	ston		<u> Tal</u>	bot		
sades	DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?		
physician. burial-transit permit. Pages 1,		Maryland Talbe	ot	Ea	ston				1 X YES 2 NO		
sit per	ERAL				101	. ZIP CODE			OF WHAT COUNTRY?		
cian. I-trans	FUNE	223 Port Street	12. WAS DECEOENT EVER IN I	U.S. ARMED	13 WAS 050	21601	IIC ORIGIN? (Specify Yes	USA	RACE — American Indian,		
physi buria		1 Never Married 2 Merried	FORCES? 1 YES	2 V NO	If yes, sp		n, Puerto Rican, etc.)	or No	Black, White, etc.		
nding s the	D BY	3√X Widowed 4 □ Divorced			'- ''-	z <u>I</u> M no specify			Specify: Black		
al or attending for use as the	ETEC	15. OECEDENT'S EDUC (Specify only highest grade of	ATION completed)	(Give kind of v	USUAL OCCUPATION		16b. KIND OF BUS	SINESS/INDUST	TRY		
pital o		Elementery/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT us	ŕ						
the hospita detached once.	COMP	17. FATHER'S NAME (First, Middle, Last)		Constr	uction	18 MOTHER'S NAI	Constru ME (First, Middle, Meiden				
be d	Ö	Charles Gardner				Mary		Surrame)			
5 should	00	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street e		TOUTE Number, City or Tow	n, State, Zip Coo	de)		
y be ret age 5 s	2	Shirley Colfield	1	9434	So. Nor	mal Ave,	Chicago,	I11.	60620		
ector, page must be		20e. METHOD OF DISPOSITION XXBurlel 2 □ Cremation 3 □ Remo	val from State cemet	LACE AND DATE	OF DISPOSITION (Na		OATE 20c. LO	CATION — City	or Town, State		
direct direct		4 Donetion 5 Other (Specify)		hapel C	emetery	ND AODRESS OF FAC	10/28/95	East	on, Md.		
ter death. Page 6 m the funeral director, oval.		18/ SI O	t t				h Funeral	Servic	es		
n by the for removal.		The trust	unce		P.C	Box 16	87, Easton	Md.	21601		
ed within 24 hou ompletely filled in al, cremation, or event, the me		23. PART . Enter the diseases, or complete the complete that immediate CAUSE (Finel disease or condition resulting in death)	et only one ceuee on eed	N D	1A G				Approximate interval Between Onset and Death		
h certificate be anding physician Hygiene prior t or other trau	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
the deat y the atte d Mental injury,	AL C	PART il. Other aignificent conditions	contributing to deeth but	not resulting i	n the underlying	ceuse given in	Part I. 24a, WAS AN	AUTOPSY	24b, WERE AUTOPSY FINDINGS		
that the ned by the and any in	EDICA						PERFOR 1 YES 2		AMILABLE PRIOR TO COMPLETION OF CAUSE		
SICIAN: The law requires the certificate has been signed a the State Dept. of Health 1, or item 23 shows an	ME						_ ' ' '		OF DEATH?		
law re as bee bept. o		DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YE	S 🗆 NO 🔊	UNCERTAIN	10				
V: The cate has State D	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	PLACE OF OEAT	H (Check only one) OTHER:						
ICIAN: ertific the S	PHYS	1 YES 2 NO	1 ☐ Inpetient 2 ☐ ER/Outpet		4 Nursing Hom	e 5 🗆 Residence					
NG PHYS fter this c eath with marked,		Netural 5 Pending	(Month, Day, Year)	26b. TIM	URY WO	RK?	26d. DESCRIBE HOW II	NJURY OCCUR	ED		
OR ATTENDING IN DIRECTOR: After Income after death Item 28 is man	D BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY -	At home, farm, e			28f. LOCATION (Street a	and Number or F	Rural Route Number,		
S after 28 I	ETEL	4 Homicide determined	building, etc. (Specify)			City or Town, State)				
L OR A	7	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowled	ige, death occurre	d at the lime, date	end place, and due	to the cause(e) end man	ner as stated.			
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that FUNERAL DIRECTOR: After this certificate has been signed by within 72 hours after death with the State Dept. of Health an STANT: It Item 28 is marked, or Item 23 shows any	COMPL		On the beele of examination e						suse(e) and manner ee stated.		
THE HOSPI THE FUNEF filed within PORTANT:	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	1 2			29c. LICENSE NUM	BER	29d. DATE SI	GNED (Month, Day, Year)		
TO THE De filed IMPOR	5	20 NAME AND ADDRESS OF SEASON	N. Fram	77		2002	50	▶ 10	24/95		
		30. NAME AND ADDRESS OF PERSON WHO	BIN, 4	15	Print)	- DUB	R, Ensi	M, 1	MD 21601		
		31. OATE FILED (MONTH, Day, Year) OCT 3 1 1995	32. REGISTHAR'S SIGNAT	Pa J. II			,	,			
) L		06131 1995	Hand an innerest	- WOLL							



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

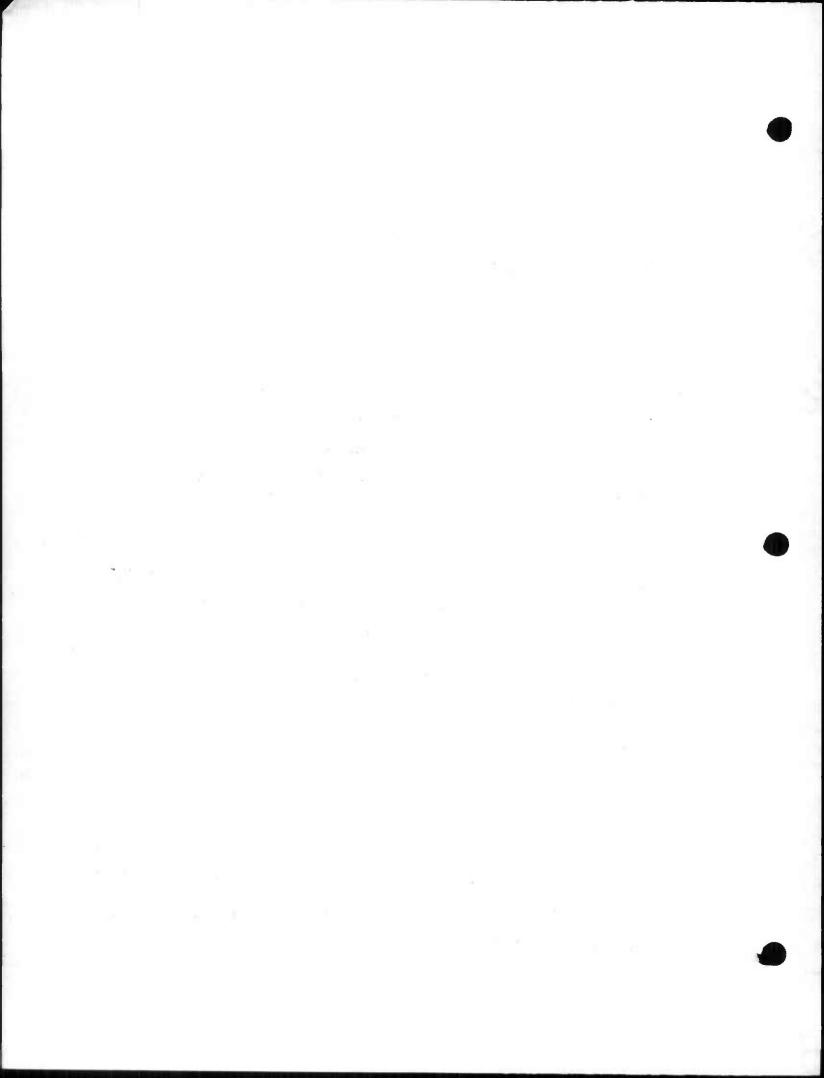
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing 4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	CATE O	F DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) JEROME	EDWARD		Gracz	yk	OCT 31	1995 '	3. TIME OF DEATH 11:27p M		
	4. SOCIAL SECURITY NUMBER 367-22-9233	1	yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) DEC • 25 , 1		BIRTHPLACE (State or Foreign Country)		
	9a. FACILITY NAME (If not institution, give s		9b. CITY. TOW	N OR LOCATION OF DE			OF DEATH			
OR B	MEMORIAL HOS				TON	A		ALBOT		
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	<u> </u>	10c. CIT	Y. TOWN OR LO	CATION		10d. INSIDE CITY			
- DIRECTOR	MARYLAND QI	UEEN ANNE	C	ENTREV	TILE 101, ZIP CODE		40. 00000	LIMITS? 1 X YES 2 NO N OF WHAT COUNTRY?		
FUNERAL	100. STREET AND NUMBER 205 ARMSTRONG	G STREET			21617			SA		
5	11. MARITAL STATUS	12. WAS DECEOENT EVER IN	U.S. ARMEO	13. WAS C	ECENDENT OF HISPAN specify Cuban, Maxica	IIC ORIGIN? (Specify Yes	s or No— 14. RACE — American Indian, Black, White, atc.			
В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	TES		ES 2 XNO Specify			Specify: WHITE		
	15. DECEDENT'S EDU		16s. DECEDENT'S	USUAL OCCUPA vork done during	TION	16b, KIND OF BUS	SINESS/INDUS	TRY		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT us	e retired.)	most or working					
4	12		CAREE	R MILI	TARY	MII	ITAR	Y		
0	17. FATHER'S NAME (First, Middle, Last)		11770		18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)			
	FRANK EDWARD	GRACZYK			JOSEI	PHINE TRO	SKY			
BE	19a. INFORMANT'S NAME (Type/Print)	·····	19b. MAILING	ADDRESS (Stre		Route Number, City or Tow		ode) 23456		
2	KATHLEEN ANN	RYDER	3852	SHERM	IAN OAKS	AVE. VI	RGIN	IA BEACH, VA		
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE	OFDISPOSITION	(Neme of			y or Town, State		
	1 Donation 5 Other (Specify)	soval from Stata SAL	ISBURY	CREMA	TORY	11-6 SAI	ISBU	RY, MD		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			AND ADDRESS OF FA					
	1	2250 50 3	45.5			ERAL HOME	-			
	23. PART I. Enter the diseases, or	MERCERON COMMISSION CO				RISON ST.				
		List only one cause on as		TOL GINGS LING	mode or dying, sae		and y and	Interval Batween Onset and Death		
	IMMEDIATE CAUSE (Final disease or condition	12000	11014	1000	000 75	30 A-G		YEARS		
	reaulting in death)	DUE TO (OR AC A	CONCEOUENCE O	E).		罗巴尔尼				
_	- RECENT MYDCHEDIAL INFARCTION									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or player)									
SAT	cause. Enter UNDERLYING	· CONG	KES TO	NE	HBART	FAIR	LR52	E		
Ē	CAUSE (Disessa or Injury that initiated evants	DUE TO (OR AS A	CONSEQUENCE O	F):						
	resulting in death) LAST	a LUNG	MA	55						
	PART II. Other algnificant conditio	na contributing to death by	ut not resulting	In the underly	ving causa given in	Part I. 24s. WAS AN	AUTOPSY	24b, WERE AUTOPSY FINDINGS		
DICAL	56,000,01	PEDTOL	HERAL		CULARI	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
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ME	DEMENT.		C DEATH VI	EC ITI NO	UNCERTAI	<u>. 186</u>		1 TYES 2 THO		
ä	DID TOBACCO USE CONT		28. PLACE OF DEA		_	N ZA				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:						
IYS	1 VES 2 NO	1 Inpetiant 2 SER/Outp	atlent 3 L DOA		INJURY AT	6 Other (Specify)	IN ILIBA OCCI	IDED		
	1 Netural 5 Pending	(Month, Day, Year)	IN.	JURY	WORK?	284. DESCRIBE NOW	INJON OCCO	nev .		
ВҰ	2 Accident Investigation	26 PLACE OF INJURY			281 LOCATION (Street	and Number o	Rural Route Number.			
0	3 Suicide 8 Could not be 4 Homicide determined 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify)									
COMPLET	29s. CERTIFIER									
MPI	29s. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and placa, and dua to the cause(a) and manner as stated. (Check only One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and dua to the cause(a) and manner as stated.									
8										
296. LICENSE NUMBER 29d. DATE STORED IN										
TO B	2.1 Wina	nela Mil			10220	140		11173		
-	30. NAME AND ADDRESS OF PERSON W ERIC F. CIGAN				RCE ST.	CENTREV	[LLE.	MD 21617		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN.	ATURE .							
	NOV 06 1995	falsa Davelson	narrall							



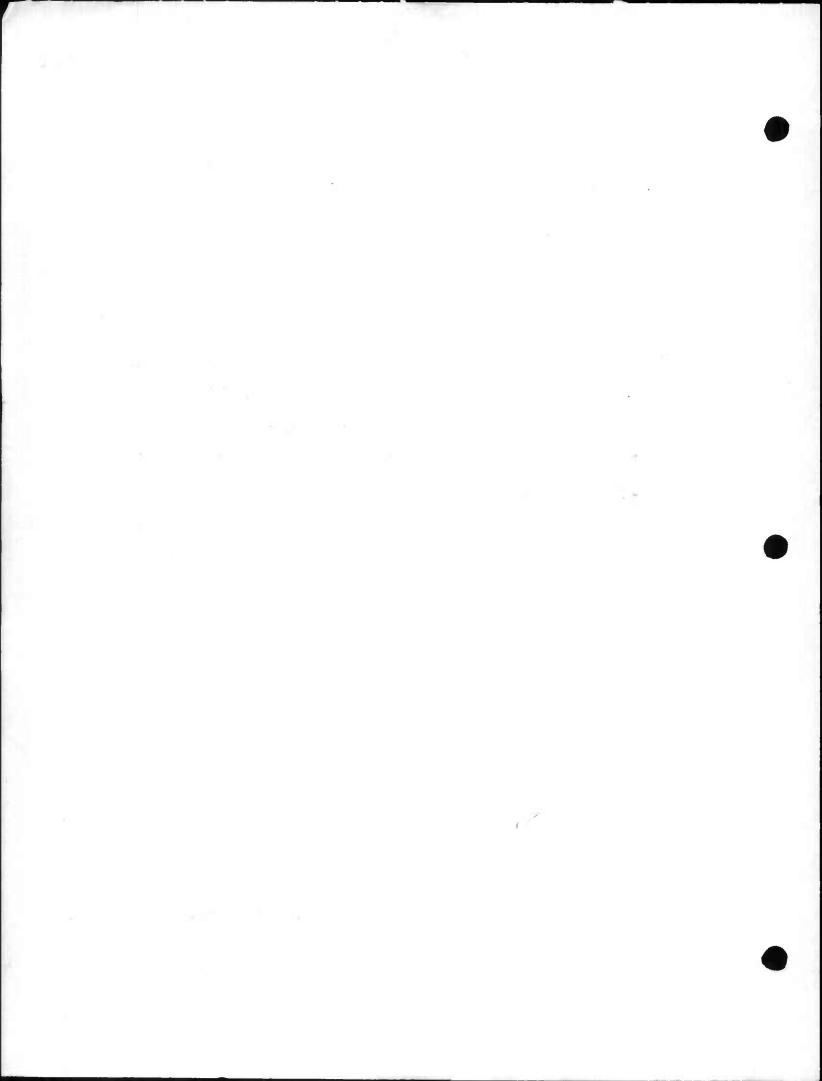
hed for use as the burial-transit permit. Pages 1, 2, 3 should after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020**

DIVISION OF VITAL RECORDS, P.O. BOX 68760

7	/	DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLANG
2	,(TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosy
1	P	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f
S	10	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
EGISTRAR	CERTIFICATE OF DEATH	REG. NO.

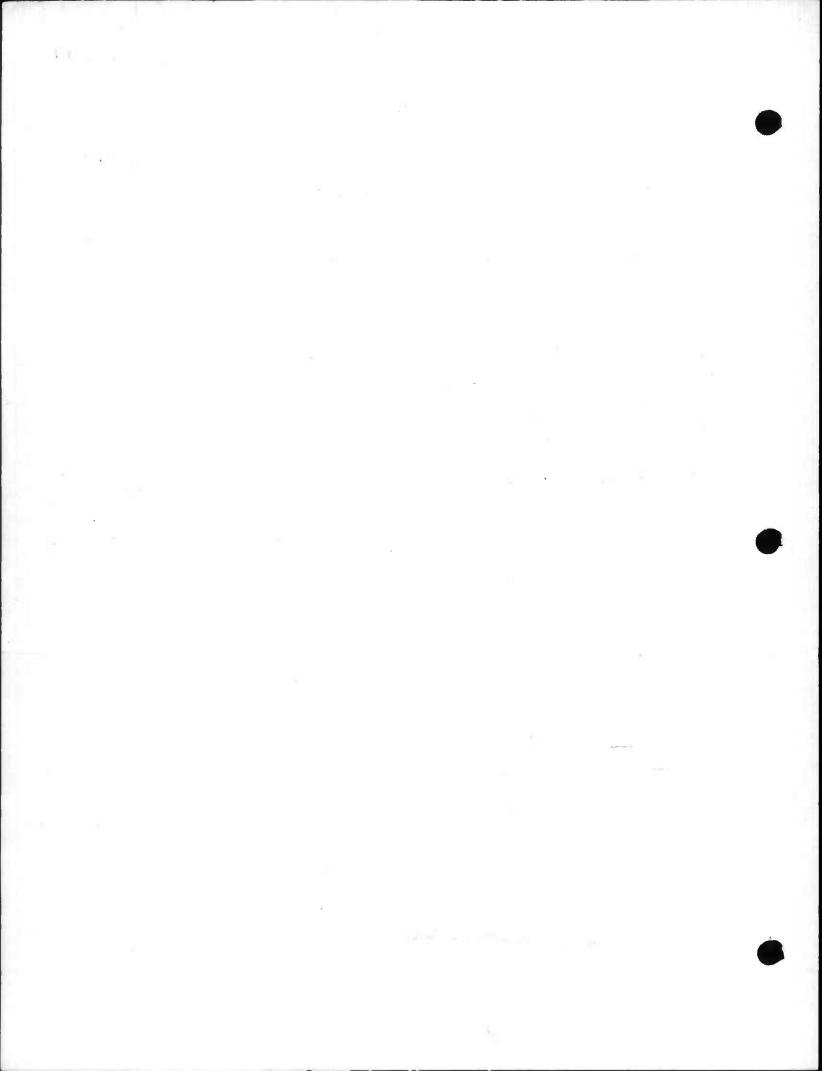
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN			F HEALTH AN	ID MEN	TAL HYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)		-				ATE OF DEATH			3. TIME OF DEAT	Ή .	
ľ	JOHN E.	GRIMES				NO		, 199		1:40	РМ	
		SEX 6. AGE (In y.	rs. last birthday) YRS.	MONTHS D	EAR IF UNDER 24 H	(A	ate of Birth forth, Day, Year) eb 2, 19		B. BIFTTHF Country,	PLACE (Stote or Fo	reign	
E .	98. FACILITY NAME (If not institution, give street SACRED HEART HOS	and number)			WN OR LOCATION O			9c. COUN	LEGA			
DIRECTOR	RESIDENCE OF DECEDENT											
H	10s. STATE 10b. COUNTY			r, TOWN OR I	OCATION			10d. INSIDE CITY LIMITS?				
	WV Miner 100. STREET AND NUMBER	al	Ke	eyser				1 YES 2 NO				
RA					10t. ZIP CODE			US.		HAT COUNTRY?		
FUNERAL	Route 2 Box 109 E	. WAS DECEDENT EVER IN U.	e ADMED	42 340	26726 DECEMBENT OF HI	ICBANIC OR	ICINIO (Caralla Var			- American Indi		
BY FU	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES :	≥ []%(O		rto Rican, atc.)	or No.	Black, Specify	Whits, stc.	en,			
	15, DECEDENT'S EDUCATION	ON 16	a. DECEDENT'S	USUAL OCCL	PATION		16b. KIND OF BUS	SINESS/INDL		white_		
	(Specify only highest grade com Elementary/Secondary (0-12)	pleted) ollege (1-4 or 5+)	(Give kind of w life. Do NOT us	vork done duri e retired.)	ng most of working							
릴	12		Engin	eer			Rail	road				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER	S NAME (FI	rst, Middle, Malden	Sumame)				
BE (Richard E. Edwa	ards			Je	an E.	. (Weave	r)				
2	19s. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (S	treet and Number or F	Rural Route I	Number, City or Town	n, State, Zip	Code)			
-	Patty Grimes				109 E:	-						
	20s, METHOD OF DISPOSITION 1	from State cemete	ACE AND DATE O	her place)				CATION — C				
	4 Donetion 5 Other (Specify)		illcres	t Bur	al Park		11/08 Ct	umber.	Land	, MD		
	Scarpelli Funeral Home											
	yames 7	S Cary	belle		mberland							
	23. PART I. Inter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, interval Between Disease or condition resulting in deeth) Approximate interval Between Onset and Death Approximate interval Between Onset and Death Onset and Death Due to (or as a conscouence of):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST											
	PART II. Other eignificent conditione or	potributing to death but	not regulting	n the unde	rhylpa cause alve	n In Part	1. 24a. WAS AN	ALITODRAY	246	WERE AUTOPSY F	INDINGE	
PHYSICIAN: MEDICAL	TAIT II. Sher algumeant constitution	on butting to death but	not resulting	The unde	inying cause give		PERFOR	MED?	240.	AVAILABLE PRIOR COMPLETION OF OF DEATH?	10	
Σ	DID TODACCO LICE CONTRID	LITE TO CALLEE OF	DEATH VE	C 171 N/	N III IINCER	TAINLE	,			1 N YES 2	NO	
AN	DID TOBACCO USE CONTRIB		PLACE OF DEAT			IAIN L	١ ا					
S	EXAMINER?	OSPITAL:		OTHER:	Home 5 🗆 Reside		Out (0					
HYS	27. MANNER OF DEATH	Inpetient 2 XEX/Outpath 28s. DATE OF INJURY	28b. TIM	E OF 28	c. INJURY AT		DESCRIBE HOW I	NJURY OCC	URED		9	
	1 Natural 5 Pending	(Month, Day, Year)	INI	URY	WORK?	0						
ED BY	2 Accident Investigation 3 Suicids 8 Could not be 4 Homicide detarmined	LOCATION (Street a City or Town, State)		or Aural A	oute Number,							
	29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.											
COMPLETED	(Check only one) XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										stated.	
BE (29b. SIGNATURE AND TITLE OF CERTIFIER	01 A		29c. LICENSE NUMBER					29d. DATE SIGNED (Month, Day, Year) ▶ NOV. 6, 1995			
2	30. NAME AND ADDRESS OF PERSON WHO CO	Church CALIFE OF DEAT	A (ITEM 97) /5	Drunt)	0.C.	.M.E		NC)∨.	0,1995)	
	DENNIS CHUTE				reet, I	Ral+	imore	Mars	/lan	d 2120) 1	
	31. DATE FILED (Month, Day, Year)					J416.		ur	Lun	2120	- 1	
	NOV 0 8 1995	JULY D'ALVELLEN	Nardall									



BALTIMORE, MARYLAND	ours after death. Page 6 may be retained by the host	I in by the funeral director, page 5 should be detache or removal.	nedical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ref hours after death. Page 6 may be retained by the host	TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

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	FOR STATE REGISTRAR	STATE OF MAR	YLAND /	DEPAR					MENTA	AL HYGIEN			710
	1. DECEDENT'S NAME (First, Middle, Last) George P. Hurcha	George P			hall			T	MON	E OF DEATH	AY	YEAR	3. TIME OF DEATH 10:35 P M
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest	birthday)	IF UNDER	1 YEAR	IF UNDE	R 24 HRS.	7. DATE	C L OF BIRTN	9]	.995	IPLACE (State or Foreign
	190-16-8506	1 M 2 D F	71	YRS.	MONTHS	DAYS	HOURS	MIN.		ary 15,	1924	Counti	nsylvania
	Sa. FACILITY NAME (If not institution, give atr	eet and number)			9b. CITY	, TOWN C	R LOCATI	ON OF DE		MILY 13,	_	NTY OF D	
DIRECTOR	Deer's Head Cent	ter			Sa	lisb	ury				Wie	comic	co
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN (OR LOCAT	TON						10d. INSIDE CITY
PIE	Maryland Wico		Sali	sbur	У						LIMITS?		
10e. STREET AND NUMBER 208 Brooklyn Ave. 10f. ZIP CODE 21801 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No- FORCES? 1 VES 2 NO 14. RACE — America. Black, White, etc. 15. Was December of Nispanic Origin? (Specify Yes or No- Hyperica Rican, etc.) 16. Race — America. 17. News Marital STATUS 18. Was December of Nispanic Origin? (Specify Yes or No- Hyperica Rican, etc.)									10g. CIT	IZEN OF V			
E.	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVEN	ER IN U.S. ARI	MED	13.	WAS DEC	ENDENT (OF NISPAN	IC ORIGI	N? (Specify Ye Rican, etc.)	s or No	14. RACE Black	— American Indian, k, White, etc.
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: White									tty:			
8	15. OECEDENT'S EOUC	ATION	16a, OE0	CEDENT'S	USUAL O	CCUPATIO)N		16	b. KIND OF BU	SINESS/INI		Le
Ħ	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gr life.	ve kind of a Do NOT us	work done se retired.)	during mo	st of worki	ng	- 1				
COMPLETED	12	1	Manu	ufacti	ring	Repre	esenta	ative		Fabr	icat	or	
8	17. FATHER'S NAME (First, Middle, Last)	77 1	1.1						ME (First,	Middle, Maiden	_		
B	Joseph 19a. INFORMANT'S NAME (Type/Print)	Hurcha						hia			Peton	9	
2	Patricia M. Hurc	h a 1 1 a	196							nber, City or Tow sbury, l			
	20a. METHOD OF DISPOSITION	IIIIII	20b.PLACEA			_		., .	OATI		CATION -		eur Céata
	1 № Burlai 2 □ Cremation 3 □ Remo 4 □ Donation ► □ Other (Specify)	val from State	Parso	netory or o	ther place)				10/		alisb		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	<u>rarsc</u>	7110 C	22.	NAME AN	D ADDRE	SS OF FA	CILITY		11130	ury,	HD
	De Javid SA	10								l Home	l : abu	war M	D 21801
	23. PART I. Entar the diseases, or co	emplications that the	sed the day	ath. Do r	not antar	tha mo	da of dy	ing, suci	h as car	rdiac or resp	iretory sr	reat,	Approximata
	ahock, or hasrt failure. L IMMEDIATE CAUSE (Final	iat only ona cause o	n asch iina.										intarval Between Onset and Death
	disease or condition									Hours			
NO N	Sequentially list conditions, b	Arterio S	Sclero	tic (Card:	io V	ascu	lar I	Dise	ase			Yrs
M	if any, lasding to immediata cause. Enter UNDERLYING	554 (51,01)	NO N 0011020	oritor o	, ,.								i i
Ĕ	CAUSE (Disease or Injury that initiated events	OUE TO (OR	AS A CONSEO	UENCE O	F):								
CERTIFICATION	resulting in death) LAST												
	PART II. Other significant conditions	contributing to daal	th but not re	auiting	In the un	derlying	cauaa	givan in	Part i.	24s. WAS AN	AUTOPSY	24b.	. WERE AUTOPSY FINDINGS
MEDICA	End Stage Renal	Disease- (Chronic	c Glo	meri	ılone	ephi	tis		PERFOI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
I III	SUBDURAL HEMATOMA									1 1 123	4- 110		OF DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEAT	TH YE	S 🗆 I	VO 🔀	UNC	ERTAIN	V				D
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	E OF DEAT	OTHER								
YSI		1 X Inpatient 2 - ER/			4 🗆 Nun	sing Hom		sidenca		er (Specify)			
	27. MANNER OF DEATH TEN Netural 5 Pending	28a. DATE OF INJU (Month, Day, Ye	er)		URY	28c. INJ	RK?	Davis		SCRIBE HOW			
2 X Accident 3 Suicide 4 Homicide SEPT. 15, 1995 1630 M 1 VES 2 XXNO FELL GOING UP STEPS								Anuto Alumbia					
								N AVE.					
29e. CERTIFIER (Check only one) 29m. CERTIFIER (Check only one) 29m. CERTIFIER (Check only one) 29m. CERTIFIER (Check only one) 2 XX MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
) and manner as stated.			
O BE	Vuenn Dulam MD (co-sign) D33905 D03599 > 10/20/95												
٩		COMPLETED CAUSE OF											
	V.A. Dulany, M.D		.O. Bo		18;	Sali	sbur	У, і	id. :	21802			
- 1	31. DATE FILED (Month, Day, Year) OCT 26 1995 July develor hardely												



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR		STATE OF N		/ DEPAR					MENTAL HYG				
	4 PROPERTIES NAME OF A MARK A STATE OF THE S										3. TIME OF DEATH 0810 M			
				6. AGE (In yrs. I	IF UNDER	IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH 8. (Month, Day, Year)		8. BIRTH	PLACE (State or Foreign		
	246-22-3317 1 🖾 M 2 🗆									Dec. 8, 1924 N			North Carolina	
OR	90. FACILITY NAME (If not institution, give street end number) 701 East Pulaski Highway					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Elkton Cecil							EATH	
ظ	RESIDENCE OF DECE	li constanti												
DIRECTOR	100. STATE 10b. COUNTY Maryland Cecil					loc. CITY, TOWN OR LOCATION Rising Sun 1 □ yes								
FUNERAL	100 STREET AND NUMBER 173 Goosemar Road						101. ZIP CODE 21911					10g. CITIZEN OF WHAT COUNTRY?		
JNE	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM					140								
BY FL	1 Never Married 2 Merried 3 Wildowed 4 Divorced 1 Never Married 2 Merried FORCES? 1 XYES IF YES, GIVE WAR OR DATE World War II				2 NO If yee, specify Cuben, Mexican, Puerto F							Yes or No— 14. RACE — American Indian, Black, White, etc. Specify: White		
ED		16. DECEDENT'S EDUCATION (Specify only highest grade completed) (6				USUAL O	CCUPATIO	N		16b. KIND OI	F BUSINESS/IN	IDUSTRY		
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)				(Give kind of work done during most of working life. Do NOT use retired.) Carpenter					Construction				
BE COM	17. FATHER'S NAME (First, Middle, Last) John C. Holbrook					16. MOTHER'S NAME (First, Middle, Maiden Flossie								
TO B	190. INFORMANT'S NAME (Type/Print) Judy Etemadi 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Potomac Ridge Court - Sterling, VA 20164											20164		
	20s. METHOD OF DISPOSITION 1& Burlet 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) Rosebank Cemetery 1995 Calvert, Maryland													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE					Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521								
	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,										Approximate interval Between			
												Onset and Death		
												10/14/15		
ATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
ERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
O	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
MEDICAL	PERFORMED? AM										WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN													
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:													
PHYS	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY WORK?													
ED BY	2 Accident Investigation				home, farm, street, factory, office 28f. LOCATION (City or Town)						Street end Number or Rural Route Number, State)			
	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.													
COMPL	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.													
BE	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										(Month, Day, Year)			
2		E. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												

E1140n, Md. 2192

31. DATE FILED (Month, Day, Year)
NOV 0 2 1995

32. REGISTRAR'S SIGNATURE

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		1 - FOR STATE REGISTRAR	STATE OF I	MARYLA			MENT (MENTA	L HYGIEI				
		1. DECEDENT'S NAME (First, Middle, Last) Clarence Holland 2. DATE OF DEATH MONTH OCTOBER 31, 1995									YEAR	3. TIME OF DEATH				
3 should		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.					IF UNDER 1 Y	FAR	IF UNDER	D 24 MDC	7 DATE	OF BIRTH			0940 IPLACE (State or Fore	M
		218-26-1729	1 📉 M 2 🗆 F		65	-		AYB	HOURS	MIN.	Feb	th, Day, Year)	1930	Count	Maryland	ign
	· c	9e. FACILITY NAME (If not institution, g		7			9b. CITY, TO							INTY OF D	EATH	
6,	СТОВ	Calvert Memorial Hospital Prince Frederick Calvert											rt			
Permit. Pages 1,	I III	10a. STATE 10b. CO			10c. CITY,	TOWN OR	OCAT	ION						10d. INSIDE CITY LIMITS?		
	DIRI		Calvert			H	untin	gto	own						1 YES 2 N	0
	RAL	10e. STREET AND NUMBER						10f.	ZIP COD				10g. CIT		VHAT COUNTRY?	
ian. transi	FUNER	215 Kyler Road					_		206					USA		
.ND 21215-0020 hospital or attending physician. tached for use as the burial-transit ce.	ВУ	1 Never Married 2 Nerried 3 Widowed 4 Divorced	I JF YES, OIVE WAR OR DATES				If y	s, spe	cify Cubi		n, Puerto	N? (Specify Yo Ricen, etc.)	es or No—		E — American Indian, k, White, etc.	
215 aften atten se as	ED	15. DECEDENT'S (Specify only highest of	EDUCATION		16a. DECE	DENT'S U	SUAL OCCU	PATIO	N		161	. KIND OF BI	USINESS/IN	DUSTRY		
ND 212 hospital or ached for us	IPLET	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Ilfe. Do	ason	,	ng mos	st of worki	ng		Self (Contr	acto:	r	
The hospit detached	COMPL	17. FATHER'S NAME (First, Middle, Last							18. MOT	HER'S NA	ME (First,	Middle, Maide	n Surname)			_
# 8 E	BE (Clarence	Ho:	11and	, Sr	•			Be.	atri	ce			Jone	es	
retained 5 should	0	19e, INFORMANT'S NAME (Type/Print)										ber, City or To				
May be on page 5 set be n		Gladys V. Hollar	ıd				ler R			unti	-	wn, MI				
Page 6 may all director, page must		20s. METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of cametery, crematory or other place. St. Edmond's UM Chr. Cem. 11/4/95 Chesapeake Beach												wn.state Beach, M	D	
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Sewell Funeral Hor										Home				
BALT after death. by the funeramoval. Ical exami		Spencer E. Sewell 1451 Dares Beach Rd. Prince Frederick										derick, M	D			
5 - 5		23. PART I. Efter the diseases, or complicatione that ceused the death. Do not enter the mode of dying, such se cardiac or respiratory arrest, shock, or heert fellure. List only one ceuse on each line. Approximeta														
	1	IMMEDIATE CAUSE (Final										Onset and D				
> = =		resulting in death) a. acute resp. favirue + CHF,														
B 5 - 5		DUE TO (OR AS A CONSEQUÊNCE OF):														
e be executed sician and con rior to burial, traumatic er	CERTIFICATION	Sequentially liet conditions, Due to jon as a consequence op:														
Sician prior	8	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Co. Caus														
certificate ding physical dygiene pri	Ē	thet Initiated events DUE TO (6R AS A CONSEQUENCE OF):														
1 5 5 0	E	resulting in death) LAST	d													
E Se se	AL C	PART II. Other algnificant condi	tions contributing to	death bu	it not res	ulting in	the unde	lying	ceuse	given in	Part I.	24a. WAS AI	N AUTOPSY	24b	WERE AUTOPSY FIND	INGS
that the that the that the and left and	2											PERFO	RMED?		AVAILABLE PRIOR TO	SE
requires the seen signed of Health and shows am	MEDIC										_	1 (2 123	A) iii		OF DEATH?	
> ~ ~ ~		DID TOBACCO USE CO	NTRIBUTE TO CA	AUSE OF	DEATH	H YES	□ NC		UNC	ERTAIN	1 🗆					
4 9 E	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	2	8. PLACE (_	(Check only	one)								
SICIAN: The Certificate the State	\Si	1 TES 2 NO	1 Di Inpetient 2		rtlent 3 🗌		OTHER: 4 - Numing	Home	5 🗆 Re	esidence	6 🗆 Oth	er (Specify)				
PHYSIC this ce with the with t	F	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF (Month, D		2	28b. TIME INJU	RY	WOF			28d. DE	SCRIBE HOW	INJURY OC	CURED		
After this death with	B	2 Accident Investigeti		DE IN HIMY	Atheni	4			ES 2 [NO						
TTEN TTOR: after	TED	3 Suicide 8 Could not 4 Homicide determine		etc. (Specif	fy)	, wrm, str	reet, factory,	OTTICE				ATION (Street or Town, State		r or Rural F	loute Number,	
Par Par	COMPLET	29a. CERTIFIER (Check only 1 CERTIFYINO PI	IYSICIAN: To the beat of	1 my knowle	dge, death	occurred	at the time	deta	end place	, and dua	to the ca	use(e) end me	enner as sta	ted.		
HOSPITAL FUNERAL WITHIN 72 TANT: II	OM		MINER: On the beele of e) end menner es state	ed.
THE HOSPI THE FUNEF filed within	BE C	296. SIGNATURE AND TITLE OF CERT	FIER		. 1		9	Т	29c. LICI	ENSE NUM	BER	. 0			(Month, Day, Year)	
S S S S S S S S S S S S S S S S S S S	0		nu 7	las	00	~~			M	DI	71	60	16	3	1/95	
	- 1	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAU	SE OF DEAT	TH (ITEM 2	27) (Type, F	Print)									

Dr. Kioumarce Yazdani

Prince Frederick, MD 20678

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	1215-0020	or attending physician.	use as the burial-transit permit. Pages 1, 2, 3 should
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

ORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within et hours after death. Page 6 may be retained by the hospital or attend	3 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires) THE FUNERAL DIRECTOR: After this certificate has been signe filed within 72 hours after death with the State Dept. of Heath

Dr. Lewis Dennis 31. DATE FILED (Month, Day, Year)

OCT 31 1995

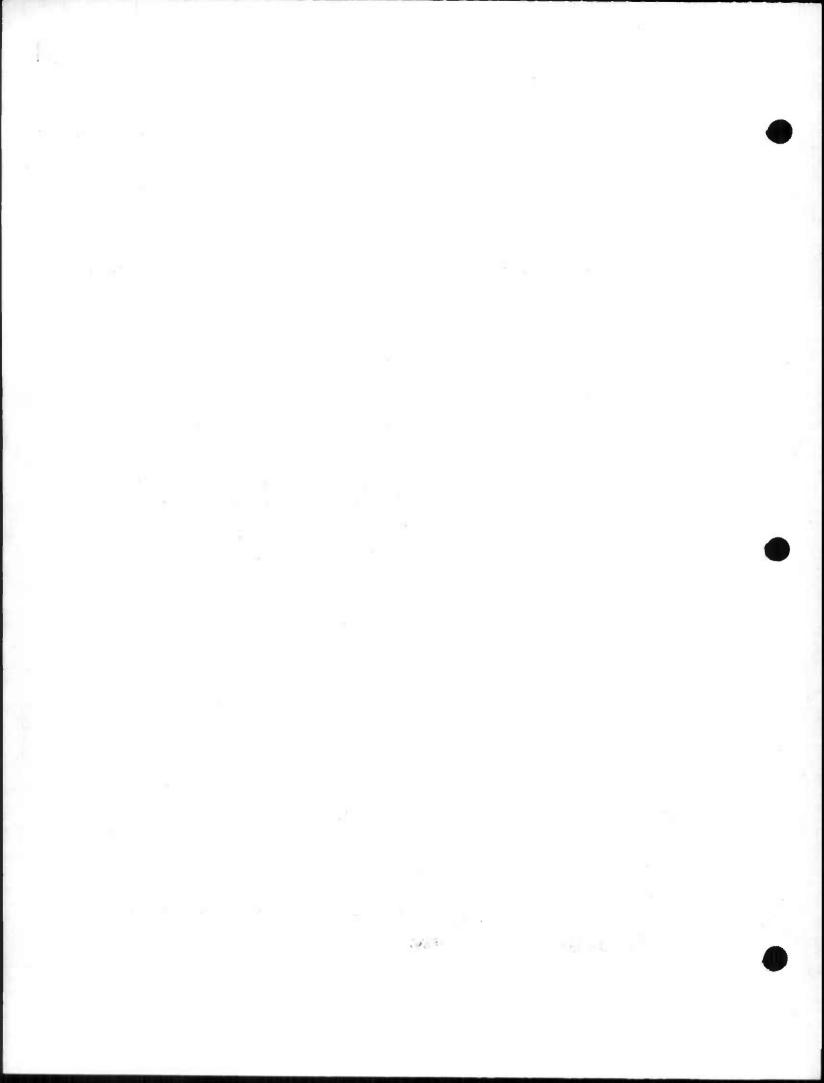
	500					
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF HEALTH A		
	1. DECEDENT'S NAME (First, Middle, Last)		CERTIFI	CALE OF DEATE	REG. NO	3. TIME OF DEATH
	LARRY	HAR	-/ /			1 1995 9. 50 PM
	4. SOCIAL SECURITY NUMBER 5.		in yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24	HRS. 7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
	578-72-7687 1 9a. FACILITY NAME (If not institution, give street	M 2 F	Mini. (Month, Day, Year) Sept 3 19			
OR BO	Washington Advent		1	Takoma Par		%. COUNTY OF DEATH Montgomery
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCATION		10d. INSIDE CITY
DIRECTOR	N/A	N/A		shington, D.	3.	LIMITS?
FUNERAL	100. STREET AND NUMBER	20		101. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?
R	1225 Valley Avenu				0005	United States
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES IF YES, GIVE WAR OR DA			HISPANIC ORIGIN? (Specify Ye Mexican, Puerto Rican, atc.) Specify:	14. RACE — American Indian, Black, White, atc. Specify:
ED	15. DECEDENT'S EDUCATE	ION	16a. DECEDENT'S I	USUAL OCCUPATION	165 KIND OF BI	Black USINESS/INDUSTRY
E	(Specify only highest grade com Elementary/Secondary (0-12) C	college (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during most of working retired.)	TOTAL CONTROL OF SEC	
COMPLET	9		Brick	Layer	Co	nstruction
	17. FATHER'S NAME (First, Middle, Last)			18. MOTHE	R'S NAME (First, Middle, Maider	Surname)
BE	Robert E. Hardy 19a. INFORMANT'S NAME (Type/Print)		100 MAN INC	ADDRESS (Obs.)	Lillie Mae B	ailey
2	Melanie Hardy			ADDRESS (Street and Number or		
157	20a, METHOD OF DISPOSITION	20b.	PLACEANDDATEO	EDISPOSITION /Name of	DATE 20c 10	DC 20011 NW
	1 Burial 2 Cremetion 3 Removat 4 Donation 5 Office (Specify)	41	Harmony Harmony	Memorial Par	k 11/2	Landover, MD
CKAMING	21. SIGNATURE OF FUNERAL SERVICE LICENS	# 1 2 0 11	,	22. NAME AND ADDRESS	OF FACILITY	
	Y LUX J- F	appel)	*		S. Pope Fund Ave SE Washi	ington, DC 20020
	27 PART I Enter the diseases, or com shock, or heart failure. List	pications that caused	the death. Do no	ot anter the mode of dying	, such as cardiac or reap	iratory screat, Approximate
	IMMEDIATE CAUSE (Final disesse or condition	0 44 111	1 A LAN	malalde	Alelah or	interval Between 9nset and Deeth
	reaulting in death)	DUE TO FOR AS A	CONSEQUENCE OF	Many Mc	Occasion of the	and in with.
		DOE DOOR AS A	CONSEQUENCE OF	8.		\
CERTIFICATION	Sequentially list conditions, If any, landing to immediate	DUE THEOR AS A	CONSEQUENCE OF	t .		
8	cause. Enter UNDERLYING CAUSE (Disease or Injury					
	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	it.		
	Todaling in dealing cool					
	PART II. Other significant conditions or	ontributing to death be	ut fot regulting in	the underlying cause give	on in Part J. 24s. WAS AN	
: MEDICAL	1 year ago	yumy	vryn	un gryw	TU YES	COMPLETION OF CAUSE
ME	- Change	or m	1240	& dhoma	W	1 🗆 YES 2 🗀 NO
Z Z	DID TOBACCO USE CONTRIB			NO UNCER	TAIN 🗂	
PHYSICIAN:		OSFITAL:		OTHER:	estituto e a locar consula incolor	
H	27. MANUER OF DEATH	Impetient 2 □ ER/Outp	28b. TIME	4 Nursing Home 5 Reald OF 38c. INJUSTY AT	ence 8 (Other (Specify) 28d. DESCRIBE HOW	BLUURY OCCUPED
BY P	1 Natural 5 Pending 2 Accident Investigation	N/A	N/A	M I YES 2 N		
	3 Suickle 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Speci	ry)		281, LOCATION (Street City or Rwin, State)	and Number or Rural Routs Number
LETE			N/A			N/A
COMPLETED				f at the time, deta and place, ar		
S		m metals of examination	and/or investigation	, in my opiaton, death occured	at the time, data and place, ar	nd due to the cause(a) and manner as stated.
BE CO	216 SECRITURE AND STREET CENTURES	UNIN	MOM	29c. LICENS	E NUMBER C	29d. DATE SIGNED (Month, Day, Mar)
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) /Toron (Print	1777	700.00,17
			f			

6201 Greenbelt Rd Suite 1 College Park, MD 20742 (301)982-2900

FOR STATE REGISTRAR
1. DECEDENT'S NA
HER
4. SOCIAL SECURIT
9e. FACILITY NAME
PRINCE
RESIDENCE C
10a. STATE
D. C.
10e. STREET AND I
2813 N
11. MARITAL STATU
1 X Never Married
a - 100 days

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	112010111111										11			1 15000 10150	
	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE	OF DEATH	W	YEAR	3. TIME OF DEA	HTA
	HEDDED	n -	III DD.	TC								- 1		10.2	E
- 1	HERBER		HARR							OC		7,	995		
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE ((In yrs. last bir		UNDER 1 YEA		MIN.	7. DATE (Mont)	OF BIRTH		8. BIRTH	IPLACE (State or I	Foreign
	F70 06 270		1 🔀 M 2 🗌 F	ч.	3.0	YRS.	NIHS DAY	A HOURS	MIN.			070			D 0
	579-96-3702		1 2 2 2		17						20,			INGTON.	DeCa
	9a. FACILITY NAME (If not in						CHY, TOV	VN OR LOCATI	ION OF DE	EATH			INTY OF D		
-	PRINCE GEO	DRGES	HOSPI	TAL (CENTE	ER 0	${\sf CHEV}$	ERLY				PF	RINC	E GEOR	GES
DIRECTOR	RESIDENCE OF DEC	PEDENT													
2	10e. STATE	10b. COUNTY	v		1.1	De CITY TO	OWN OR LO	CATION						10d. INSIDE CIT	rv
ž I	IOM. STATE	100. 000111	•		1.7	, , , , , , , , , , , , , , , , , , ,	OWIN ON EC	JOHNON						LIMITS?	.
5	D. C.					WAS	HING	TON						1X YES 2	NO
	10s, STREET AND NUMBER							101. ZIP COD)F			10a, CIT	IZEN OF Y	WHAT COUNTRY?	
ا ک									_						
NERA	2813 NAYLO	OR RD.	, S. E.	#A81	4			200	20				U. S	. A.	
ξ	11. MARITAL STATUS		12. WAS DECEDE	ENT EVER II	N U.S. ARMEI)	13. WAS	DECENDENT (OF HISPAN	NIC ORIGIN	N? (Specify Yea	or No-	14. RACI	E — American in	dlan.
ď	1 X Never Married 2	Marriad	FORCES?	1 YES	2 NO		If yes	, specify Cubi	an, Maxica	n, Puerto	Rican, etc.)		Blac	E — American inc k, White, etc.	
- 1	3 Widowed 4 Divo		IF YES, GIVE	WAR OR D	DATES		1 🗆	YES 2 X NO	Specify	y:			Spec		
ן מ	3 Widowed 4 Divo	rced												BLACK	
9	15. DEC	EDENT'S EDU	CATION		16a. DECED	ENT'S USI	JAL OCCUP	PATION		168	. KIND OF BUS	INESS/IN	DUSTRY		
-	(Specify only	y highest grade	completed)		(Give I	tind of work NOT use re	done during	g most of worki	ing						
<u>"</u>	Elementary/Secondary (0	12)	College (1-4 or	5+)	W. DO	1101 030 10	41100./								
<u> </u>	11TH GRADE				STI	JDENT	1								
SOM CO	17, FATHER'S NAME (First, M	liddin Last)						18. MOT	HER'S NA	ME (First	Middle, Maiden	Sumame)			
ا د	I THAT I										modely maidely				
u	HENRY EDWA	RD JEN	NINGS					MA	RION	II.	HARRIS				
	19a, INFORMANT'S NAME (19b. M	AILING AD	DRESS (Str	eet and Numbe	er or Rural i	Aoute Num	ber, City or Town	n, State, Zi	ip Code)		
2											LOS FRES				
	MARION I. H				281	3 NAY	LOR	RD., S	5. B.	A8	314 WA	SH.	D. C	20020	
	20a METHOD OF DISPOSIT 1 Durini 2 Crematic	ION			b. PLACEAND			N (Neme of		DAT	TE 20c. LO	CATION -	- City or To	own, State	
	1 A Buriel 2 Crematic		oval from State	cen	metery, cremat	ory or other	place)	AL PAR	V	1.70	/31LAN	DOM	D M	D	
					HARMO	NI PLE)/ JITHIN	DOVE	II, PI	<u> </u>	
	21. SIGNATURE OF FUNERA	L SERVICE LA	CENSEE	1)	/			E AND ADDRE				AT 1	CME		
	5//. /	/	DX		6	-	PIN	CKNEY-	SPAN	IGLER	R FUNER	AL B	OME		
	peod	arol	-116	hec	Nn	Ry	524	- 8TH	I ST.	, N.	E. W	ASH.	, D.	C. 200	02
\neg	23. PART I. Enter the d	Iseases or													
			complications ti	hat cauae	d the death	. Do not	enter the	mode of dy	lng, suc	h ss car		ratory e	rreat,	Approxi	mata
			complications to List only ones			. Do Not	enter the	mode of dy	ying, suc	ch ss car		ratory e	rreat,		mata Between
	shock, or h	eart fallure.				Portor		^	ying, suc	ch ss car		ratory e	rreat,	Interval	
	shock, or h IMMEDIATE CAUSE (Fin disease or condition	eart fallure.				2		^	ying, suc	ch ss car		ratory e	rreat,	Interval	Between
	shock, or h	eart fallure.	List only one c	ause on e	-8L	F		mode of dy	ying, suc	Sh ss car		ratory e	rreat,	Interval	Between
	shock, or h IMMEDIATE CAUSE (Fin disease or condition	eart fallure.	List only one c	ause on e		F		^	ying, suc	Sh ss car		irstory e	rreat,	Interval	Between
2	shock, or h IMMEDIATE CAUSE (Fin disease or condition	eart fallure.	List only one c	ause on e	-8L	F		^	ylng, suc	Sh ss car		ratory e	rreat,	Interval	Between
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending ph	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bu	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
24 hours after death	filled in by the fune	ion, or removal.	the medical exam
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he death certificate	the attending physic	Mental Hygiene pri	njury, or other to
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G PHYSICIAN: The	er this certificate ha	ath with the State D	narked, or item
TAL OR ATTENDIN	TAL DIRECTOR: After	72 hours after dea	If Item 28 is n
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296 SIGNATURE AND TITLE OF CHATIFIER

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95 34792 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 3. TIME OF DEATH 2. DATE OF DEATH October Jene VIRV 12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Fo Country) 1 M 275 F 217 09 2018 YRS. 92 Sept. 27,1903 Maryland Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Villa Rosa Nursing Home <u>Mitchellville</u> Prince George's 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Riva Maryland Anne Arundel 1 YES 2 XNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21140 404 Westbury Drive <u>United</u> States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XX NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexicen, Puerto Rid 1 ☐ YES Z(X NO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES ВУ Specify: 3 Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk U.S. Government once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) F Charles H. Richardson Mary E. Ebersole BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Mary Hubbell Clemmons 404 Westbury Drive Riva Maryland 21140 eg. 20e. METHOD OF DISPOSITION
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■ Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 4 Donation 6 Other (Specify) Cedar Hill Cemetery 10/30/95 Suitland Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY oble Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximats shock, or heart fallure. Liet only one cause on sach line. Interval Retwe IMMEDIATE CAUSE (Finsi Onset and Death 章 years disease or condition resulting in death) MEMOSCIENOTE CA event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE amy 1 TYES 2 NO OF DEATH? shows 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN A 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Rem HOSPITAL: OTHER: 1 TYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 28b. TIME OF INJURY 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 28e. PLACE OF IRJURY — At home, farm, street, tactory, office building, stc. (Specify) 1 Natural ВУ 1 YES 2 NO Investigation 2 Accident 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28 Is COMPLETED 6 Could not be 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(e) end menner as stated.

39 MAME AND ADDRESS OF PERSON, WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A JEWEHM 420

31. DATE FILED (Month, Day, Year)

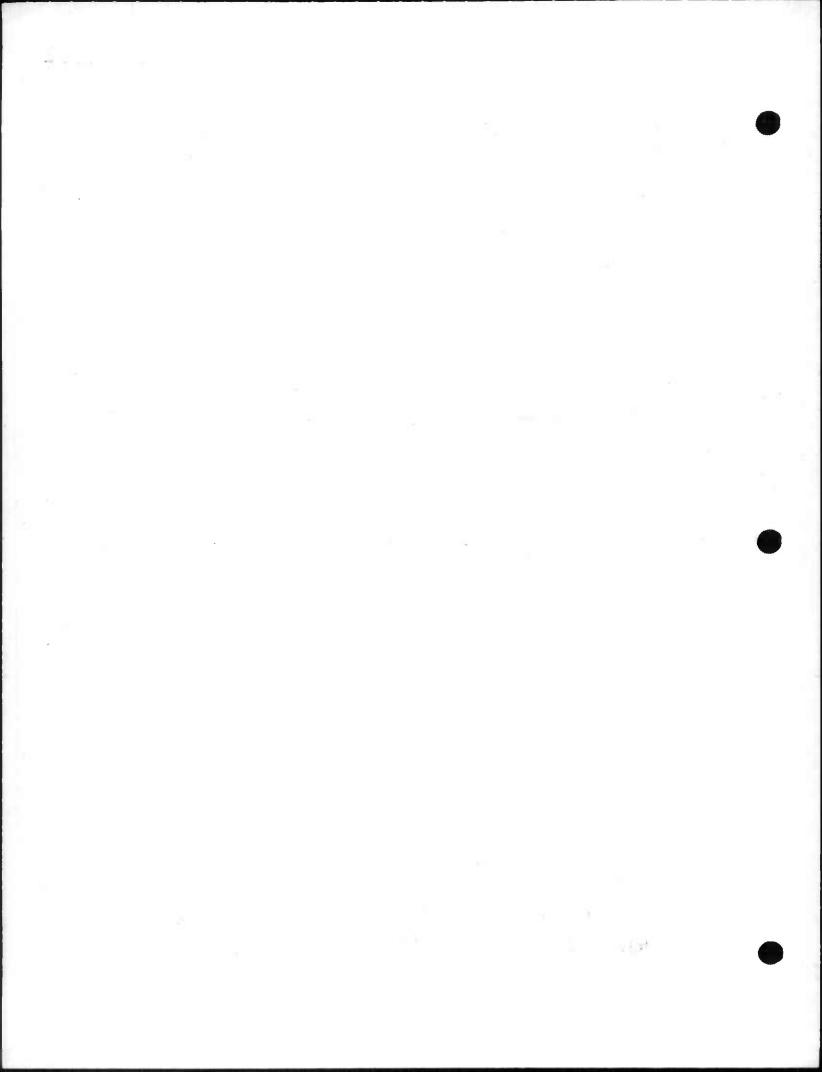
32. REGISTRAR'S, SIGNATURE

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29c. LICENSE NUMBER

29d, DATE SIGNED (Month, Day, Year)



funeral director, page 5 should

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ELIZABETH MaryHUSSEY OCTOBER 28 1995 0330 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH 1922 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 579-36-0202 Washington, D.C. 1 M 2 X F 73 YRS 27, February 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH Washington Adventist Hospital DIRECTOR TAKOMA PARK, MARYLAND MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Hillcrest Heights 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3378 Curtis Drive, Apt. 101 20746 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 📉 Widowed 4 🗌 Divorced Specify: Black COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only h Ashton & Ashton Building Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Custodian and Maintenance Company once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 15 Joseph Dewitt Ashton Bessie Umbrella Lindsay BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gilbretta Ashton-Jones (daughtet) 3418 Chelsea Drive, Woodbridge, Virginia 22192 must be 20e, METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION (Name of Nov. 2, 1995 20c. LOCATION — City or Town, Stata Arlington National Cemetery 4 Donation 5 Other (Specify) Arlington, Virginia 22. NAME AND ADDRESS OF FACILITY Latney's Funeral Home the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lalney 3831 Georgia Avenue, N.W.; Wash.D.C. 20011 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or haert failure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death TICEMIA disease or condition_ ZWEEKS resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) YEAR CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate HEPATIC . Enter UNDERLYING WEFFR CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 10 YEARS ò injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY REBRO VASCULAR ACCIDEN shows any 1 TES 2 NO ECIPHERAL VASCULAR DISEASE 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES
NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) HOSPITAL:

1 Minpetient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO 4 🗌 Nursing Home 5 🗋 Residence e 🗀 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 284 DESCRIBE HOW INJURY OCCURED 1 Netural 1 YES 2 NO BY Investigation Accident 28a. PLACE OF INJURY — At home, term, street, tactory, offica building, etc. (Specify) 99 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide Item 29a. CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. TO THE FUNERAL OF THE FUNERAL DE FILE WITHIN 72 TO THE FUNERAL DE TRANSPORTANT: It IN (Check only one) 2 MEDICAL EXAMINER: On the basis estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

V. SINGH 7209A HANDVER PARKWAY GREENBELT MD20770

144.5°

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG NO

		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR	TMENT OF	HEALTH AND		GIENE G. NO.	
		1. DECEDENT'S NAME (First, Middle, Last					2. DATE OF DE	ATH DAY	YEAR 3. TIME OF DEATH
,		Hilda Hartk 4. SOCIAL SECURITY NUMBER	1					1995	7:55 p M
P/		213-12-4854A	1 M 2 XF 9	8 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIR (Month, Day,		8. BIRTHPLACE (State or Foreign Country) Maryland
2, 3 should	СТОВ	9a. FACILITY NAME (If not institution, give Nursing & Reh				or location of D nbridge	EATH	9c. COUN	Dorchester
)es 1,	EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY	10c. CIT	Y, TOWN OR LOCA	ITION			10d. INSIDE CITY
permit. Pages 1,	L DIRE	Maryland Do	rchester			ambridge	e	10-07	LIMITS? 1 X YES 2 NO EN OF WHAT COUNTRY?
. <u>F</u>	FUNERAL	107 Vue de Lea	u Street			216	13	log. CITIZ	U.S.A.
hours after death. Page 6 may be retained by the hospital or attending physician, ed in by the funeral director, page 5 should be detached for use as the burial-transit or removal. or removal. medical examiner must be notified at once.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES	NO	13. WAS DE	CENDENT OF HISPAI pecify Cuban, Maxico S 2 A NO Specifi	NIC ORIGIN? (Spei an, Puerto Ricen, a ly:	city Yea or No-	14. RACE — American Indian, Black, White, atc. Specity: White
w attend use as	ED	15. DECEDENT'S ED (Specify only highest grad		a. DECEDENT'S	USUAL OCCUPATI	ION cet of working	16b. KIND	OF BUSINESS/INDU	
ospital or thed for u	APLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	o retired.)			Depart	ment Store
the hospit e detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle,		
should be	BE	John Henry Sc 19a. (NFORMANT'S NAME (Type/Print)	hmidt					ne Kayl	
5 should	2	John Schmidt				I.eau Si			, MD. 21613
nay be page		20a -METHOD OF DISPOSITION		ACEANDDATE	OF DISPOSITION (N			Oc. LOCATION — C	
ge 6 ma frector, p		1 🗗 Burial 2 🗆 Cremation 3 🗆 Res 4 🗆 Donation 5 🗆 Other (Specify)	0 0	y, crematory or or ak Lav	ther place) Vn. Ceme	eterv	11-6	Balti	more, MD.
ler death. Page 6 m the funeral director, val.		21. SIGNATURE OF FUNERAL SERVICE L	SON-FONI	10000	Curra	nd address of fa	vell Fu	neral	Home, P.A. MD. 21613
ed within 24 completely fill al, cremation event, the	N	immediate CAUSE (Finel disease or condition resulting in death)	complications that caused the List only one cause on each s	Fai	· lure	ode of dying, suc	th as cardisc or	respiratory erre	Approximats Interval Between Onest and Death
th certificate be en ending physician a I Hygiene prior to or other traum	CERTIFICATION	Sequentielly list conditions, if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in deeth) LAST	DUE TO (OR AS A CO						
7 20 -	MEDICAL	PART II. Other significent condition	ns contributing to death but r	not resulting i	in ths underlyin	g ceuse given in	P	MAS AN AUTOPSY ERFORMED? YES 2 NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
been sign to of Heal	×	DID TOBACCO USE CONT	TRIBLITE TO CALISE OF T	DEATH VE	S NO S	UNCERTAI			1 TES 2 NO
SICIAN: The law requestrible to the State Dept. of the State Dept. of the Control	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.		H (Check only one)		A LJ		
ICIAN: The certificate I the State or Item	YSIC	1 TES 2 TONO	HOSPITAL: 1 Inpetient 2 ER/Outpetien	nt 3 🗆 DOA	OTHER: 4 Nursing Hon	ne 5 🗆 Realdence	8 Other (Speci	fy)	
NG PHYSIC fler this cer auth with the marked, I	ву Рну	27. MANNER OF DEATH 1 Scatural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	URY WO	JURY AT DRK? YES 2 NO	28d. DESCRIBE	HOW INJURY OCCU	URED
OR ATTENDING DIRECTOR: After hours after death tem 28 is man	ETED E	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — j building, atc. (Specify)	At home, term, a	street, fectory, offic		28f. LOCATION (City or Town	Street and Number of State)	r Rural Route Number,
対域に ==	COMPLE		SICIAN: To the best of my knowledge ER: On the basis of exemination an						
THE HOSPI THE FUNEF filed within PORTANT:	- 11	296. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI			SIGNED (Month, Day, Year)
TO THE TO THE De fied IMPOR	TO BE	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEATH	(ITEM 27) (Type.	Print)	028	209	>N	012,1955
		Edmund J. Ma	cLaughlin, M	.D., 4		a St.,	Cambri	.dge, M	D. 21613
		31. DATE FILED 1000 003 199	5 32 SEPISTRATIA BIOLOGIA	Mardall			-	**	

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

D THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Za hours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed wirthin 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlat, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
타	HI DI	be file	IMP0

31. DATE FILED (MOORD, Day Year) 1995

	FOR 1 - STATE	STATE OF MA	ARYLAND / D					MENTAL	HYGIEN	E			
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CEF	TIF	CATE OF	DEAT	Н		REG. NO				
	IDA MAY HARRISON							2. DATE OF MONTH	DV	AY 1.0	YEAR	3. TIME OF DEATH	
-	4. SOCIAL SECURITY NUMBER	5. SEX 6	8. AGE (In yrs. lest bit	ton de s		1 2000		OCT.	31	19	95	10:33A	
	153-01-2313	1 M 2 N F			MONTHS DAYS	# UNDER	MIN.	7. DATE OF (Month, E	lay, Year)	110	Count	HPLACE (State or Form) JERSEY	wign
1	9a. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY, TOWN	OR LOCATIO	N OF DE	JUNE	12,1		INTY OF C		
H	34094 OLD OCEAN C				PITTSV					200	COMI		
5	RESIDENCE OF DECEDENT									AA T.	COM	-	
DIRECTOR	10e. STATE 10b. COUNTY		1		TOWN OR LOCA	TION						10d. INSIDE CITY LIMITS?	
	MARYLAND WICOM	1100		PIT	TSVILLE							1 YES 2 1	NO
RA	34094 OLD OCEAN C	TTV DOAD				O 1 O E C				10g. CIT		WHAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER BUILD ARMS	· D		21859				L.,	USA		
	1 Never Married 2 Married		YES 2 NO		If yes, ap	ecify Cuba	n, Mexica	IC ORIGIN? (n, Puerte Rica	Specify Yes in, etc.)	or No-	Blac	E — American Indiar k, Whita, etc.	n,
BY	3 XWidowed 4 Divorced	IF TES, GIVE WAR	n On DATES		1 YES	2 X NO	Specify				Spec	WHITE	
CD.	15. DECEDENT'S EDUC (Specify only highest grade of		16a, DECES	DENT'S U	JSUAL OCCUPATE	DN out of workin		16b. KI	ND OF BU	SINESS/IN	DUSTRY		
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do	NOT use	retired.)	at or worter							
COMPLET	11		HOM	1EMA	KER								
	17. FATHER'S NAME (First, Middle, Lest) ALBERT BORK							ME (First, Mick		Surname)			
BE	19a, INFORMANT'S NAME (Type/Print)							REMUS					
٥	DIANE TAYLOR				ADDRESS (Street a							m 010E0	
	20g. METHOD OF DISPOSITION			-	F DISPOSITION (N		IYI		20c. LO			MD 21859	
	1 Burial 2 Cremation 3 Ramo	val from State	cemetery, cremeter	tory or oth	er place) CEMETEL	V			1			MARYLANI	`
	21. SIGNATURE OF BUNERAL SERVICE LICE	ENSER	7/1/2/1	تلطط	22. NAME A	ND ADDRES		YTLIE					7
	Somarel	X X	ller		ZELLE	R FUN	ERAI	HOME	, 12	12 01	LD O	CEAN CITY	Z RD
	23. PART I. Enter the diseases, or co	- Vilentian Maria			P. O.	ROX	3171	- SAL	LSBUR	N Y	D 21	802	
	25. I Arty I. Litter the diseases, or ci		death ade beauses		A A Ab	14 4 1		, DILL.					_
- 1	shock, or heart fellure. L	lat only one cause	caused the death e on each line,	h. Do no	ot enter the mo	de of dyl	ng, suci	as cardia	or respi	ratory ar	rest,	Approximation interval Bet	tween
	enock, or heart fellure. L	lat offly one cause	e on each line,		ot enter the mo	de of dyl	ng, suci	as cardia	or respi	ratory ar	rest,	Approximatinterval Bet Onset and	tween Death
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7	immediate cause (Final disease or condition resulting in death)	DUE TO (O	on each line.	ENCE OF)	ot enter the mo	de of dyl	ng, suci	n as cardia	or respi	ratory ar	rest,	Approximatinterval Bet Onset and	tween Death
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BE COMPLETED BY PHYSICIAN: MEDICAL CE	enock, or heart reliure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions N C A P = 0 25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO 27. MANNER OF DEATH Netural 5 Pending Investigation Netural 5 Pending Investigation Ould not be detarmined Ould not be detarmined Ould not be Check only One) 2 MEDICAL EXAMINER MEDICAL EXAMINER MEDICAL EXAMINER PARTIFIER Check only One) 2 MEDICAL EXAMINER	DUE TO (O PUL N DUE TO (O C H DUE TO (O C	PR AS A CONSEQUE PR AS A CONS	ENCE OF) ENCE OF) ENCE OF) Uiting in 1	26. PI The underlyin The underlyin The underlyin 28. IN The underlyin The underlyin 28. IN The underlyin The underlyi	g cause g	EATH (Che sidence	Part I. 24 1 1 1 26 Other (S 286, DESCR 286, LOCATI City or 1 to the cause time, date an IBER	ia. WAS AN PERFOR YES 2 ON (Street is own, State)	AUTOPSY MED? NO NJURY OC	24b CURED or Aural interest of the cause(to the cause(t	Approximatinterval Bei Onset and Onset and Approximation of the Approxim	Death Death State of the State
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires TO THE FUNERAL DIRECTOR: After this certificate has been signible filed within 72 hours after death with the State Dept, of Healt IMPORTANT: If Item 28 is marked, or Item 23 shows:

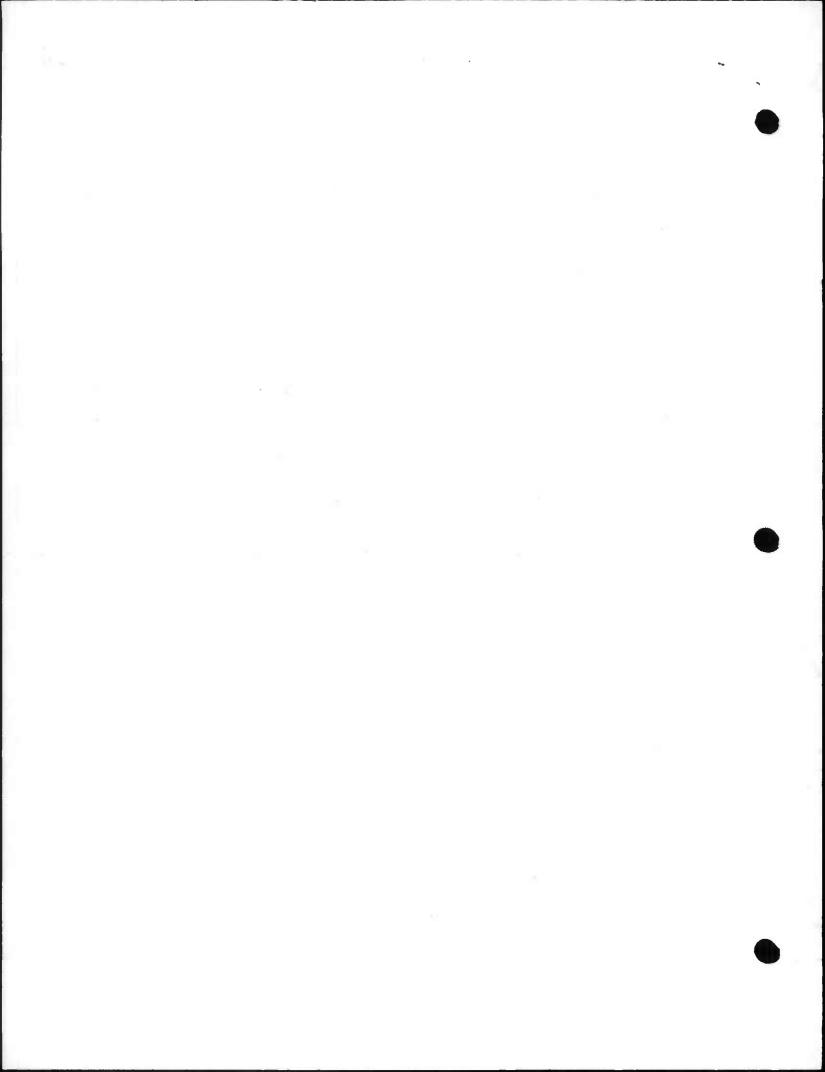
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

18

	if. Pages 1, 2, 3 should	
or attending physician.	poletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 st cremation, or removal.	
in mours after death. Page 6 may be retained by the hospital or atte	hould be detached for	iffed at once.
Page 6 may be ret	Il director, page 5 :	niner must be notified at once.
nours after death.	lled in by the funera n, or removal.	e medical exami
e executed within	vysician and completely fi prior to burial, crematio	ws any injury, or other traumatic event, the medical exam
at the death certificate be	e attending physicia ental Hygiene prior	iry, or other trail
ires that the	signed by the fealth and M	ws any inju

TO BE COMPLETED BY FUNERAL DIRECTOR

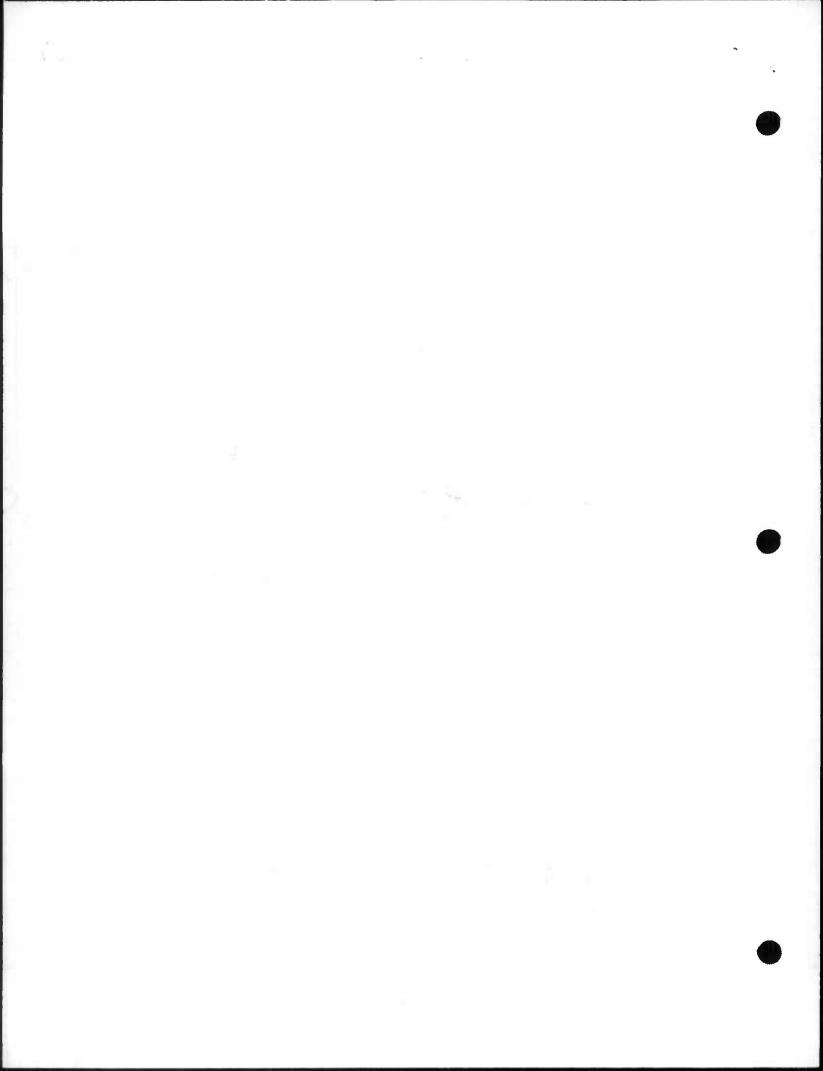
FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAL	HYGIEN	E	
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH		3. TIME OF DEATH
GLENN FRANKL:	IN HOLLOWA		UNDER 1 YEAR	IF UNDER 24 HRS.	NOV	. 02	, 199	
216-56-1363	1 Ø M 2 □ F 31		NTHS DAYS	HOURS MIN.	(Month,	27/6		BIRTHPLACE (State or Foreign Country) aryland
9a. FACILITY NAME (If not institution, give stre	eet and number)	9(b. CITY, TOWN (OR LOCATION OF DE	ATH		9c. COUNTY	
4516 Red House	e Road		Snow	Hill			Wor	cester
10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	TION				10d. INSIDE CITY
Md. Word	cester		Snow					1 YES 2 NO
	_		101	. ZIP CODE				OF WHAT COUNTRY?
4516 Red House	Road 12. WAS DECEDENT EVER II	III C ADMED	1 40 1110 000	218		A	U.S	
1 Never Merried 2 Married	FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPAN ecify Cuban, Maxica	n, Puerto Ric	(Specify Yea can, etc.)	or No.— 14.	RACE — American Indien, Black, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 TYES	2 NO Specify	<i>i</i> :			white
15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	18e. DECEDENT'S US	done durina ma	ON ast of working	16b. R	KIND OF BUS	INESS/INDUS	TRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	lite. Do NOT use re	etired.)		0	wn F	Arm a	nd Broiler
12		Farmer	& Br	oiler	G	rowe	<u>r</u>	
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA				
Gerald F. Holl	Loway							olloway
Kimberly R. Ho	211011211			nd Number or Rural F				,
20s. METHOD OF DISPOSITION						_		Md.21763
1 X Burial 2 Cremation 3 Ramon 4 Donation 5 Other (Specify)	rai from State cem	PLACE AND DATE OF D etery, crematory or other	plece)		DATE	1		or Town, Stata
21. SIGNATURE OF FUNERAL SERVICE LICE		Bates Me		ST COM.		4 Sn	OM HT	11, Ma.
A) to :.	10.			nis Fun		HOm	е	
23. PART I. Enter the disesses, or co	19. Del	mus	P.0	. Box 8	7,Sn	ow H	ill,M	d.21863
immediate cause (Finel	Say INFL	ech line.					100 - 100	Approximeta Interval Between Onset and Death
Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events		CONSEQUENCE OF):						
resulting in deeth) LAST								
PART II. Other significent conditione	contributing to deeth b	ut not recuiting in t	he underlying	g ceuse given in		24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
					_			1 TES 2 NO
DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES		UNCERTAIN	۱ 🗆 ۱			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (Check only one) THER:					
1 X YES 2 NO	1 Inpatient 2 ER/Outp	atlant 3 DOA 4	☐ Nursing Hom	e 5 KReeldence	8 Other (Specify)		
1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	/ Wo	URY AT RK? (ES 2 NO	28d. DEŞCI	RIBE HOW IN	IJURY OCCUR	ED
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stree	et, factory, offic		28f. LOCAT City or	TION (Street a Town, State)	nd Number or I	Sural Route Number,
29e. CERTIFIER	1							
(Check only 1 CERTIFYING PHYSICI	AN: To the best of my know On the basis of examination							suse(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	in de la			29c, LICENSE NUM		1		GNED (Month, Day, Year)
Downthy C. 1	Regiosth,	m.d.		2062	41		> 11-	-3-95
30. NAME AND ADDRESS OF PERSON WHO	HOLZWOX	ATH (ITEM 27) (Type, Pri	nt)	SINK S	- 5	· COLL	Here	Mo, 21763
NOV 03 1995	32 REGISTRAR'S SIGN.	ATURE		-1011 31	,	TON	made	1165 W. W.



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AI CERTIFICATE OF DEATH		
		1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH MONTH DAY	3. TIME OF DEATN
		Annie E. Dillard Hawkins	Oct 27	1995 11:55 Am
P		220-26-89/3 10 m 2 m 7 77 rms.	HRS. 7. DATE OF BIRTH (Month, Day, Year) Dec., 29, 191	8. BIRTNPLACE (State or Foreign Country) & UIFGIOLO
2, 3 should	OR	9a. FACILITY NAME (If not institution, give street and number) The Pines Easton	OF DEATN 9c.	COUNTY OF DEATH Talbot
	2	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION		10d, INSIDE CITY
mit. Pages	L DIRECTOR	Maryland Talbot Cordova		LIMITS? 1 YES 2 NO
transit pe	FUNERAL	12801 Richland Lane 216	25	Le S. A.
the burial-transit permit.	BY FU	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 12. WAS DECEMBENT EVER IN U.S. ABMED 13. WAS DECEMBENT OF H 14. WAS DECEMBENT OF H 15. WAS DECEMBENT OF H 16. WAS DECEMBENT OF H 17. WAS DECEMBENT OF H 18. WAS DECEMBENT OF H 19. WAS DECEMBENT OF H 19. WAS DECEMBENT OF H 11. WAS DECEMBENT OF H 11. WAS DECEMBENT OF H 12. WAS DECEMBENT OF H 13. WAS DECEMBENT OF H 14. WAS DECEMBENT OF H 15. WAS DECEMBENT OF H 16. WAS DECEMBENT OF H 17. WAS DECEMBENT OF H 18. WAS DECEMBENT OF H 19. WAS DECE	IISPANIC ORIGIN? (Specify Yes or N faxican, Puerto Rican, etc.) Specify:	o— 14. RACE — American Indian, Black, White, atc. Specify: Black
88	ED I	15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION	16b. KIND OF BUSINES	
d for use	COMPLETE	(Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use retired.) [Give kind of work done during most of working life. Do NOT use retired.)	0:1	11
be detached at once.	DMF	17. FATNER'S NAME (First, Middle, Lest) 18. MCTNER	S NAME (First, Middle, Maiden Surna	
	BE CO	George H. Dillard Ann	ie Elizabet	h Jarvis
5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or I	Rural Route Number, City or Town, Sta	te, Zip Code)
ige 5	-	Thelma. S. Miller 1737 E. 35th St.	Baltimore, 1	Maryland 21218
tor, pa		20a, METHOD OF DISPOSITION 1 To Burlai 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of central control of the place)	OATE 20c. LOCATIO	DN — City or Town, State
direc		4 Donation 6 Other (Specify) Engineer A. M. E. Churc 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS C	ch 11/4/95 Lape	ville, Virginia
e funera al. examir	- 3	Keith El Wharton Po Bur 1	John Or	Nerns tuntome Lox Va. 23413
completely filled in by the funeral director, page rial, cremation, or removal. c event, the medical examiner must be		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, shock, or heart fellura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):	such sa cardiec or reapirator	y arrest, Approximata Interval Between Onset and Death Weck
ending physician and Hygiene prior to bu or other traumati	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):	Le fleromber	month
by the atternated when the state of the stat	A	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause give	en in Part I. 24s. WAS AN AUTO PERFORMEON	AVAILABLE PRIOR TO
been signed to pt. of Health and 3 shows any	EDIC	- sarcoid of the lung	1 TYES 2 1	COMPLETION OF CAUSE OF DEATH?
of h	Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WOUNCER	TAIN 🗆	1 TYES 2 NO
2 6 gg	AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	IAIN L	
certificate h the State d, or Item	SIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 inpetient 2 ER/Outpetient 3 DOA 4 Normaling Normal 5 Reside	ence 6 Other (Specify)	
with the ked, or	PHYSICIAN:	27. MANNER OF DEATN 28a. DATE OF INJURY (Month. Day, Year) 28b. TIME OF 28c. INJURY AT WORK?	28d. OESCRIBE NOW INJURY	Y OCCURED
After this death with marked	ВУ	1 Accident Investigation M 1 YES 2 NO	0	
after d	0	3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)	281. LOCATION (Street and Nu City or Town, State)	imber or Rural Route Number,
400	MPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at		
FUNERAL within 72 TANT: IL	00	No. SUBLIANCED AND THE SUBSECTION		
TO THE FUNERA De filed within 7 IMPORTANT: I	3 BE	29c. LICENSE 29c. LICENSE 29c. LICENSE 29c. LICENSE		DATE SIGNED (Month, Day, Year)
	10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT B. SANCHEZ SUB Idlewild Ave Ea		
	انه	31. DATE FILED (Month, Day, Year) 1995 32. AEGISTRAR'S SIGNATURE	a l VVI	.00/



TO THE HIGSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with "A flower after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEALL DIRECTOR: A text mits certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be field within 72 hours after death with the State Debt. (or Headled) within 12 hours. (Femalon, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
--

	1 - FOR STATE OF MARYLA		RTMENT OF			MENTAL HYGIEN			
- 9	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH
	Ethel Maud Harring	rton				NOV.		95 3	3 · 30 A M
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	8	. BIRTHP	LACE (State or Foreign
	219-44-2107 1 □ M 2 X7 F	93 YRS.	MONTHS DAYS	HOURS	MIN.	8/17/1902	M	ary!	Land
	9e. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOW	OR LOCATI	ON OF D	PEATH	9c. COUNT	Y OF DE	ATH
DIRECTOR	Salisbury Nursing & Rehab Center	er	Salis	oury,	Md.	21801	WICC	MICC)
E	10e. STATE 10b. COUNTY	10c. Cl	TY, TOWH OR LO	CATION					10d. INSIDE CITY LIMITS?
5	Maryland Wicomico	Sa.	lisbury						1 YES 2 NO
A	10e. STREET AND NUMBER			101. ZIP COD	E				IAT COUNTRY?
FUNERAL	1028 Fairground Drive			21801			150	USA	
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN 1 FORCES? 1 YES	U.S. ARMED				NIC ORIGIN? (Specify Y	s or No- 1	4. RACE	- American Indian, White, etc.
BY F	1 Never Merried 2 Merried IF YES, GIVE WAR OR DAT		1 U Y	ES 2 NO	Speci	an, Puerto Rican, atc.)		Specify	
									willce
핃	15, DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of	work done during	TION most of working	ng	16b. KIND OF BI	JSINESS/INDU	STRY	
9	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT (
COMPLETED	8	House	wife	1					
	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maide r Hitchens			
BE	John Wesley Revelle								
2	19e, INFORMANT'S NAME (Type/Print)					And Angelon Police Number, City or To		851	104/10
	Sharon M. Beauchamp				, ,	ocomoke, M			
			of disposition		ck	11/6 Sal	ocation — ci .isbury		
	21. SIGNATURE DE FUNERAL SERVICE LICENSEE		Mers	AND AFTER	ièra	1911 Home			
	Sert S. Melso	~	РО В	ox 64,	, Po	comoke Cit	y, Md.	. 2	1851
	23. PART i. Enter tha diaaases, or complications that caused shock, or haart failure. List only one cause on as		not antar tha	moda of dy	ing, su	ch aa cardiac or res	piratory arre	et,	Approximate interval Between
	IMMEDIATE CAUSE (Final								Onaet and Death
	disease or condition resulting in death)	Nence	Pon	remo	mo	à			30Ays
	disease or condition resulting in death) a. Recure DUE TO (OR AS A)	CONSEQUENCE	OF):			0			
z	multip	le f	no	ST	431	s paren	now	52	
CERTIFICATION	Sequentially list conditions, If any, leeding to immediate	CONSEQUENCE	OF):						
S	cause, Enter UNDERLYING CAUSE (Disease or Injury	nem	4						
TE	that initiated events DUE TO (OR AS A (CONSEQUENCE	OF):						
E	d								
	PART II. Other algnificant conditions contributing to death bu	it not reaulting	in the underly	ing cause	given i		N AUTOPSY		WERE AUTOPSY FINDINGS
MEDICAL	Depression					PERF	PRMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ED	Depression						-6-110		DF DEATH?
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH Y	ES NO	□ UNO	CERTA	N Z			1 120 2 100
AN			ATH (Check only o						
PHYSICIAN:	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpe	ntlent 3 DOA	OTHER:	lome 5 □ B	lesidence	8 Other (Specify)			
H	27. MANNER OF DEATH 28e. DATE OF INJURY	28b. TI	ME OF 28c.	INJURY AT		28d. DESCRIBE HOW	INJURY OCCI	JRED	
	1 Netural 5 Pending (Month, Day, Year)		M 1 [WORK? YES 2	NO				
ВУ	3 Suicide 28e. PLACE OF INJURY	At home, term	, street, factory, c	ffice		281. LOCATION (Street		r Rural Ru	oute Number,
H	4 Homicide determined building, etc. (Special	(4)				City or Town, Star	6)		
H	29e. CERTIFIER (Check call) CERTIFYING PHYSICIAN: To the beat of my knowle	doe, death occu	rred at the time.	late and place	e, end du	ue to the couse(s) and m	anner en state	d.	1,100
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the besis of exemination								end menner es stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				ENSE N				(Month, Day, Year)
BE	200. SIGNATURE AND THE OF CERTIFIER			-	-	98,3	1		3/9
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA	TH (ITEM 27) /7/2	ne Print)		>	, 0, -	V	1 -	

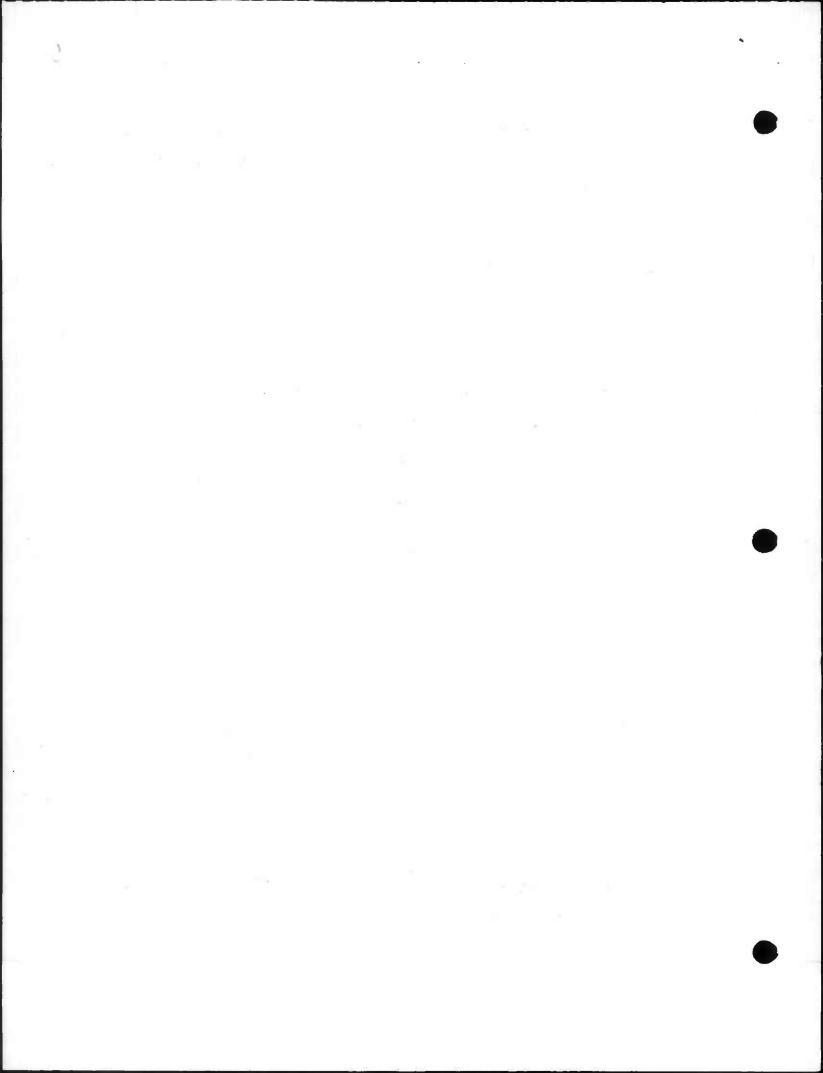
1104 32. REGISTRAR'S SIGNATURE

1995

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should		
	g physician.	e burial-transit permit		
	oital or attendin	d for use as th		
	ned by the hos	ould be detache		lled at once.
()	6 may be retail	ector, page 5 sh		must be notif
	HYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.	the funeral dire	loval.	IPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
,	this sours a	etely filled in by	emation, or rem	nt, the medic
	be executed wi	cian and compl	ior to burial, cre	raumatic ever
	death certificate	attending physi	ental Hygiene pr	ry, or other t
	quires that the	n signed by the	f Health and Me	lows any inju
	IAN: The law re	rtificate has bee	n the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	or item 23 sh
	S P	R: After this cer	er death with th	is marked,
	THE HOSPITAL OR ATTENDIN	THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with 1	VT: It item 28
	TO THE HO	TO THE FUI	be filed with	IMPORTA!

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2, DATE OF DEATH		3. TIME OF DEATH
	THOMAS	PAUL H	ALES,	IV		OCT, 24		25 2 PM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birtnday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1 0.	BIRTHPLACE (State or Foreign
	204-66-8115 9a. FACILITY NAME (If not institution, give st		4 YAS.	ONTHS DAYS	HOURS MIN.	04/08/71		Maryland
Œ	Greenbriar Swa		91		w Hill	-AIR		rcester
DIRECTOR	RESIDENCE OF DECEDENT							LOCDUCE
R	10a. STATE 10b. COUNTY	•	10c. CITY, T	TOWN OR LOCATI	ON			10d. INSIDE CITY LIMITS?
		cester		Salis	bury			1 TES 2 NO
3AL	10e. STREET AND NUMBER			10f.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	7505 Snow Hil				2180			S.A.
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 TYES	U.S. ARMED	13. WAS DECE	NDENT OF HISPAN	IIC ORIGIN? (Specify Yes n, Puarto Rican, etc.)	or No— 14.	. RACE — American Indian, Black, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		2 X NO Specif			Specify:
	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S US	UAL OCCUPATION	N .	16b. KIND OF BUSI	INESS/INDITES	white
Ē	(Specify only highest grade Elamentary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use n	k done during mos etired.)	t of working	Too. KIND OF BOSI	INC33/INDO3	TRI
7	12	1	Clerk			Giant	Food	Store
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden S	Surname)	
BE	Thomas Paul Ha	les, III			Debor	ah H. Ha	les	
9	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street an	d Number or Rural i	Route Number, City or Town	, State, Zip Co.	de)
F	Thomas Paul Ha	les, III	404 Fr	reid D	r.,Daug	ohin, Pa.	1701	8
	20a. METHOD OF DISPOSITION 1 IX Burial 2 □ Cremation 3 □ Ramo		PLACE AND DATE OF D		ne of	DATE 20c. LOC	ATION City	or Town, Stata
	4 Donation 5 Other (Specify)	P	arsons (emete	ry	10/27 Sa	lisbu	ry, Md.
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE DIO	\$h		ADDRESS OF FA	eral HOme		
	Patricia	, Li-Lle	mus				now H	ill,Md.21863
	23. PART I. Enter the diseases, or c	complications that caused List only one cause on ea	the death. Do not	enter the mod	e of dying, auc	h as cardiac or reapir	atory srreat	, Approximate
	IMMEDIATE CAUSE (Final	List Only One Cause on ea	ich ime.					Interval Between Onset and Desth
	disease or condition resulting in death)	DUE TO (OR AS A	WOUND	TO 1	EFT C	YEST		IMMEDIATE
		DUE TO (OR AS A	CONSEQUENCE OF):					
NO	Sequentially list conditions,)	201125011112					
A	if any, leading to immediate cause. Enter UNDERLYING	DOE TO (OH AS A	CONSEQUENCE OF):					
딢	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE DF):					
CERTIFICATION	resulting in death) LAST	4						
	PART II Other elapificant conditions	a acatalbutlan to disat b			Control of the			
SAL	PART II. Other algorificant conditions	s contributing to death bi	it not reaulting in t	the underlying	cause given in	Part I. 24a. WAS AN A PERFORM		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă						1 YES 21	NO NO	COMPLETION OF CAUSE OF DEATH?
Σ	DID TODA COO LICE COA ITE			5 5				1 TES 2 NO
AN	DID TOBACCO USE CONTR				UNCERTAIL	1 🗆 📗		
2	EXAMINER?	HOSPITAL:		THER:				0
PHYSICIAN: MEDIC	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp	28b. TIME O			8 X Other (Specify) H'(Snow Hill, MD
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	Y WOR		and begoning from its	JUNI OCCUR	
B	2 Accident Investigation 3 Suicida 6 Could not be	28a. PLACE OF INJURY	— At home, farm, stree			28f. LOCATION (Street ar	nd Number or F	Rural Route Number,
COMPLETED	4 Homicide detarmined	building, atc. (Speci	f(y)			City or Town, State)		
Ä	29a. CERTIFIER t CERTIFYING PHYSIC	CIAN: To the best of my knowle	edge, death occurred a	t the time date a	nd place, and due	to the cause(s) and many	ar as eleted	
N N								ause(s) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c, LICENSE NUM			IGNED (Month, Day, Year)
H	Strotte 1	Tobunt!	71. 1.		D062			-25-95
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	int)				
< $ $	DOROTHY C.	HUZUDETH	200	SNULL.	50	SUNIAL	HUI	MD, 21763
	31. DATE FILED (Month, Day, Year)	22 DECISTRAD'S SIGNA	TURE			2.00%	1000	
	OCT 26 1995	Julia Sendem	Rudshills					



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE CONTENTION OF PROPERTY THE PERSON OF THE
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31. DATE FILED (Month, Day, Year)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending physician.
lan and c
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 28,1995 OCTOBER LEROY HOLLAND JR. 2:55 a. m 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS 1 3/M 2 - F 216-14-2054 AUG. 18 1923 MD 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF GEATN 9c. COUNTY OF DEATH DIRECTOR (RESIDENCE) 4149 HARMONY RD PRESTON CAROLINE ING. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD CAROLINE PRESTON 1 📉 YES 2 🗌 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4149 HARMONY RD. 21655 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 \square NO IF YES, CIVE WAR OR DATES 1/15/43-1/9/4611. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No 14. RACE — American Indian, Black, White, etc. Il yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried BY 1 - YES 2 1 NO Specify 3 X Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 09 LABORER LANDSCAPING 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) LEROY HOLLAND SR BE LILLIAN MARY THOMAS 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ELEANOR BOULDEN SMITH VILLIAGE ST APT#68 EASTON, MD. 21601 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE netery, crer 4 Donation 5 Other (Specify) CEME. **VETERANS** 11/6/95 HURLOCK, MD 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WILLIAMSON-FLUHARTY FUNERAL SERVICE 319 E. DOVER ST. EASTON, MD. 21601 I. Enter tha diseasea, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ ARDIAC. resulting in death) TERUSCLEROTIC CARDIOVASCULAR DISCASE MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 1 TES 2 THO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO lent 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 5 Pending Investigation Natural BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tactory, offica building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piecs, and due to the cause(e) end menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occur red et the time, date end piace, end due to the cause(e) end manner ee stated. D TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mont). Day, Year) BE 10 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATH **4**7995 october 31, 1229 P 11 Dunning Beatrice Jorgensen 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 1925 Wante ACE (State or Foreign 69 535 14 1860 1 - M 2 F permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH SOLUTIONS CALVELL Solarans Nursing Center DIRECTOR RESIDENCE OF DECEDENT Maryland 106. COUNTY VERT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY St. Leanard 1 TYES 2 NO FUNERAL 10a. STREET AND NUMBER 10f, ZIP COD 20685 10g. CITIZEN OF WHAT COUNTRY? 5516 Beach Drive United States be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Maxican, Puerto Rican, etc.)

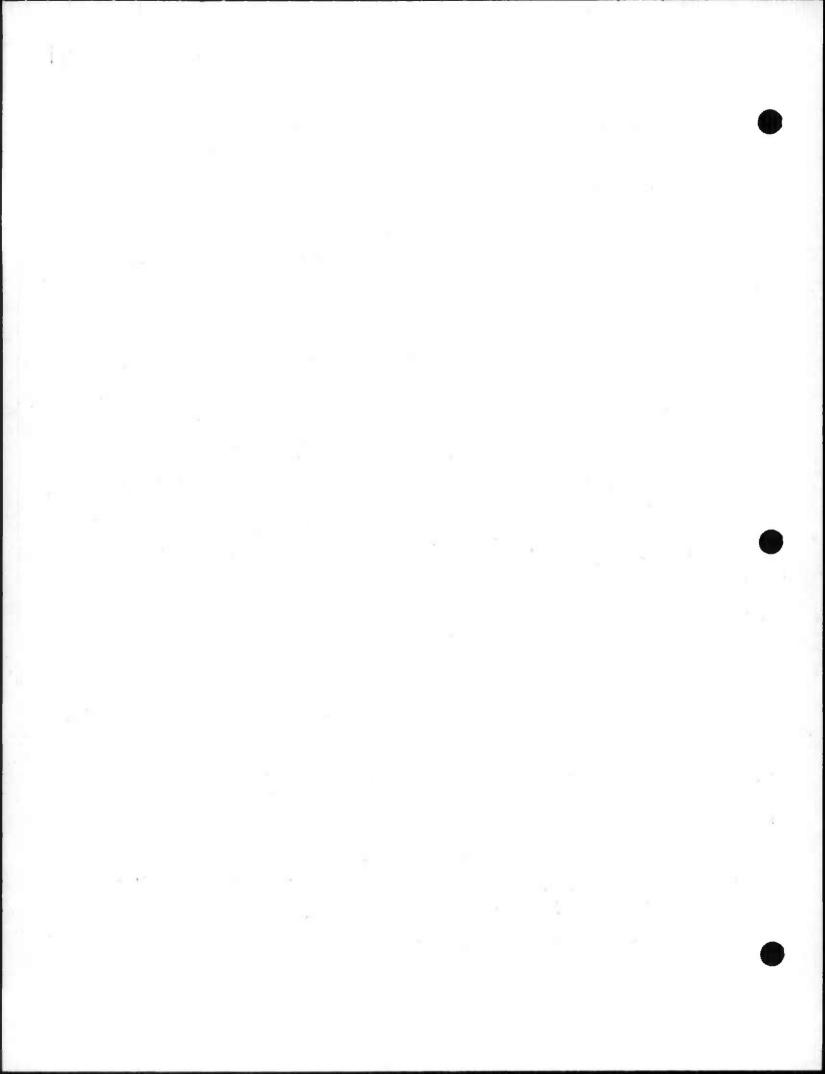
1 YES 2 NO Specify: В 3 Widowed 4 Divorced white ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondery (0-12) College (1-4 or 5+) public school/ self employeed COMPL 5+ teacher/meeting planner 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Charlotte Brown Farl Durning BE notified funeral director, page 5 should 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Jack C. Jorgensen 5516 Beach Drive St. Leonard, Maryland 20685 death. Page 6 may be be 20s. METHOD OF DISPOSITION
1 ☐ Burlal 2 分 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Committee, crematory, crematory or other place)
Vectropolitan Funeral Service 1, 1995 must 20c. LOCATION - City or Town, State Alexandria Virginia examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home ,P.A. we executed withir 24 hours after de, sian and completely filled in by the full of to burial, cremation or execution or executions. 4405 Broomes Is. Rd. Port Republic Maryland 20676 medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart fallure. List only one ceus interval Betw **IMMEDIATE CAUSE (Finel Onset and Death** the disease or condition___ nalignant high grade astro ce toma resulting in death) event. DUE TO (QF) AS A CONSEQUENCE OF): certificate be executed traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician it of Health and Mental Hygiene prior to cause. Entar UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF that initiated eventa reaulting in death) LAST 6 the death Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO requires that any COMPLETION OF CAUSE 1 TYES 2 NO DF DEATH? Shows 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{D}\) NO \(\overline{\pi}\) UNCERTAIN \(\Boxed{D}\) PHYSICIAN: has be Dept. MB 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) The ltem! After this certificate death with the State HOSPITAL OTHER: 1 TES 2 LNO OR ATTENDING PHYSICIAN: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Netural 5 Pending 1 YES 2 NO В 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide 60 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / COMPLETED 8 Could not be 4 Homicide 28 Item 29e. CERTIFIER

(Chark only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. FUNERAL within 72 h HOSPITAL = 2 MEDICAL EXAMINER: On the To the Hospita To the Funera be filed within 7 IMPORTANT: I of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MM 043306 10 9 30 NAME AND ADDRESS OF PERSON WHI COMPLETED PAUSE OF DEATH (ITEM 27) (Type, Print)

> 32. REGISTRAR'S SIGNATURE Jelin Davidson Rardall

1995

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020	6 may be retained by the hospital or attending physician.	ctor, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	nust be notified at once
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIN	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Ze hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

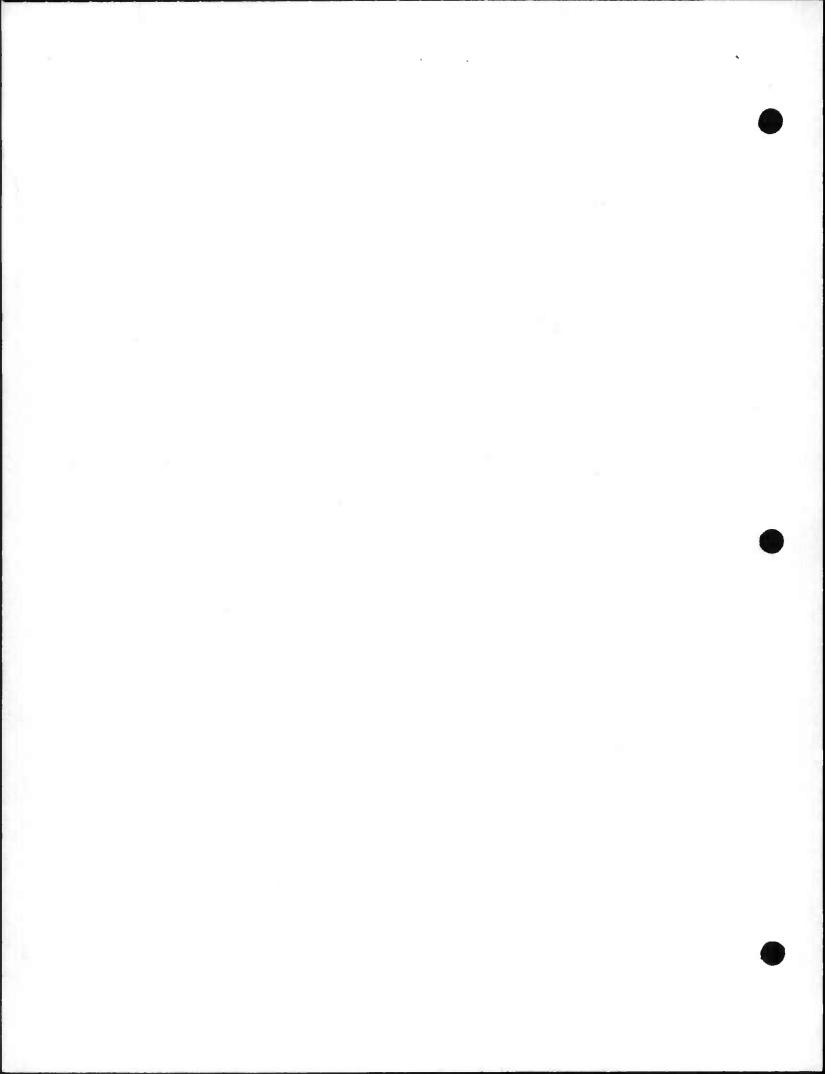
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31. DATE FILED MONIN.

ชี 3 "1995

	FOR 1 STATE	STATE OF I	MARYLAN					MENTAL HYGIEN	E					
	REGISTRAR			CERTIF	ICATE (OF DEA	TH	REG. NO.						
	1. DECEOENT'S NAME (First, Middle, Last)				ning.		2. DATE OF DEATH		3. TIME OF DEATH				
	EARL T.					sones	5	Dovember		95 0436A M				
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rrs. last birthday)	IF UNDER 1 Y	AR IF UND	R 24 HRS.	7. DATE OF BIRTH		. BIRTHPLACE (State or Foreign				
1	219-36-5544	1 , M 2 F	55	YRS,	MONTHS D	YS HOURS	MIN.	(Month, Day, Year)		Country)				
1	9a. FACILITY NAME (If not institution, give		25	1000	at orry To	WEL OF LEAST		09/16/4		Md.				
l oc	ALL THE SECTION AND ASSESSMENT OF THE SECTION AND ASSESSMENT OF THE SECTION AND ASSESSMENT OF THE SECTION ASSESSMENT OF TH	SCHOOL STATE		on Man D	96. CHY, 10	WN OR LOCAT				Y OF DEATH ICOMICO				
ē	PENINSULA REG	IONAL MED	ICAL (CENTER		5A.	LISBU	KI	W	TCOMICO				
ပ္ပ														
DIRECTOR	Md WC	rcester			Y, TOWN OR L					10d. INSIDE CITY LIMITS?				
		rcester		G	irdle	tree				1 TYES 2 X NO				
FUNERAL	10e. STREET AND NUMBER					10f. ZIP COI	DE		10g. CITIZE	N OF WHAT COUNTRY?				
Ē	6416 Taylor'	6416 Taylor's Landing Road 21829 U.S.A.												
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.	S. ARMED	13. WAS	DECENDENT	OF HISPAN	IC ORIGIN? (Specify Yes	or No- 14	I. RACE — American Indian.				
	1 Never Married 2 Married	FORCES? 1				s, specify Cub YES 2 [X NO		n, Puerlo Rican, atc.)		Black, White, etc.				
B	3 Widowed 4 Divorced					LEG I (X)	Specify			Specify: White				
8	15. DECEDENT'S ED	UCATION	16	a. DECEDENT'S				16b. KIND OF BUS	SINESS/INDUS					
<u> </u>	(Specify only highest green (S	College (1-4 or 5		(Give kind of a	work done during se retired.)	g most of work	ing	self-	emple	wed				
7	10	College (I-4 of 5		plumb:	ing &	heat	ina			Heating				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			padmo.	-1119 u			ME (First, Middle, Meiden		neating				
-	Albert Casey	Jones				2000								
B	19a. INFORMANT'S NAME (Type/Print)	oones		1				etta Pow						
ဥ								loute Number, City or Town						
	Millie E. JO	nes		6416	Tay.	lor's	Lan	ding Rd.	,Giro	lletree, Md.				
	20a, METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Re-	moval from State		ACE AND DATE		N /Name of		OATE 20c. LO	CATION - CIT	y or Town, State				
	4 Donation 5 Other (Specify)			ringh		emete	rv	11/5 Gi	rdlat	ree.Md.				
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	10		22. NAN	E AND ADDR	ESS OF FAC	HLITY		TEE/MU.				
	A DIDIA	~	Min	1	D	ennis	Fun	eral HOm	е					
	1 auroca		very	P.O. Box 87. Spour Hill Md 21862										
	I 43. PARI I. ENTER THE DISCUSSES. OF						40	TASHOW H	7 . M	0. 21863				
	ahock, or heart feilure	complications that. List only one cau	t caused th	ne daath. Do r	not entar tha	moda of dy	ing, such	as cardiac or reapi	ratory arres	t, Approximata				
	anock, or heart feiture	List only one cau	t caused the	ne daath. Do r n line.	not entar tha	moda of dy	/ing, such	aa cardiac or reapi	ratory arres	t, Approximata interval Between Onset and Death				
	IMMEDIATE CAUSE (Final disease or condition	List only one cau	t caused the	ne daath. Do r	not entar tha	mode of dy	ring, such	as cardiac or reapi	ratory arres	t, Approximata Interval Between				
	anock, or heart feiture	a	ise on each	ne daath. Do n i line.	ot entar tha	mode of dy	ying, such	as cardiac or reapi	ratory arres	t, Approximata Interval Between				
Z	immediate Cause (Final disease or condition resulting in death)	a	ise on each	est	ot entar tha	mode of dy	ying, such	a a cardiac or reapi	ratory arres	t, Approximata Interval Between				
ION	immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions,	a. Due to	(OR AS A CO	est	F):	mode of dy	ring, such	a aa cardlac or reapl	ratory arres	t, Approximate Interval Between Onset and Death				
CATION	anock, or heart return anock, or heart return	a. Due to	(OR AS A CO	ONSEQUENCE OF	F):	mode of dy	ring, such	a aa cardlac or reapl	ratory arres	t, Approximate Interval Between Onset and Death				
FICATION	anock, or heart return anock, or heart return	a. Due to b. Due to c.	(OR AS A CO	ONSEQUENCE OF	P):	mode of dy	ring, such	as cardiac or reapi	ratory arres	t, Approximate Interval Between Onset and Death				
RTIFICATION	anock, or heart return anock, or heart return	a. Due to b. Due to c.	(OR AS A CO	PASEQUENCE OF	P):	mode of dy	ying, such	a aa cardlac or reapl	ratory arres	t, Approximate Interval Between Onset and Death				
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32 JEGISTRAR'S SIGNATUR

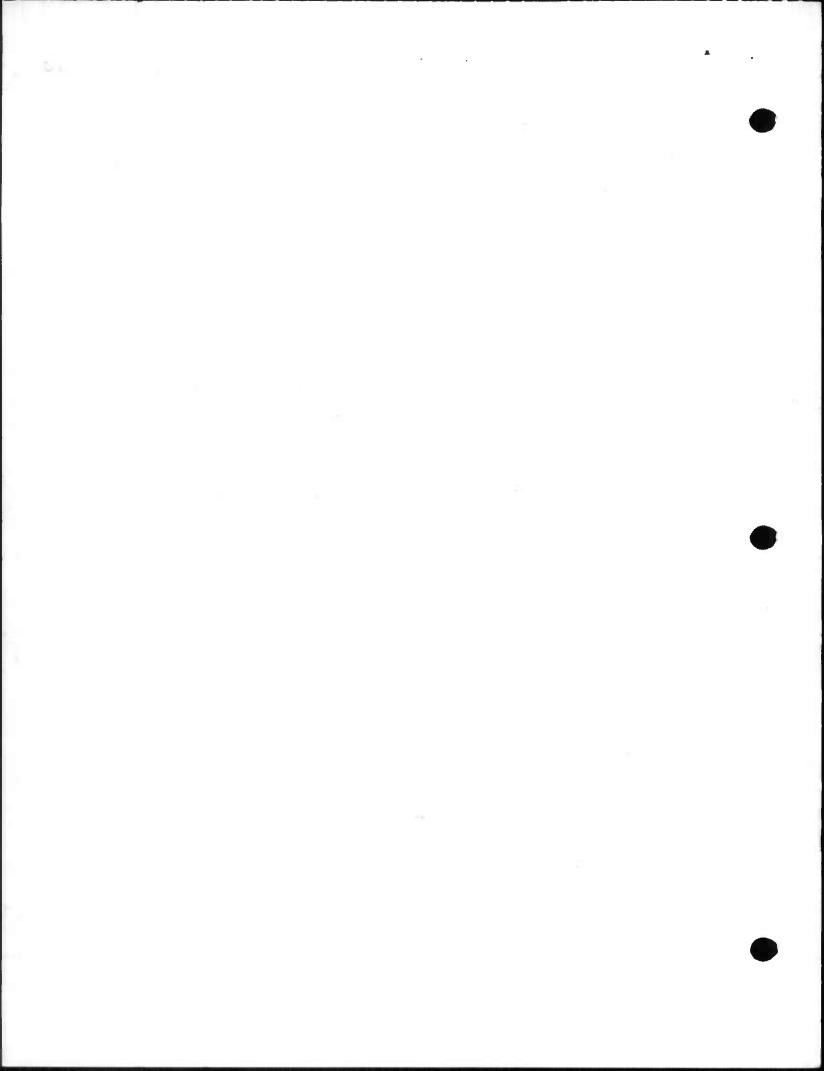


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

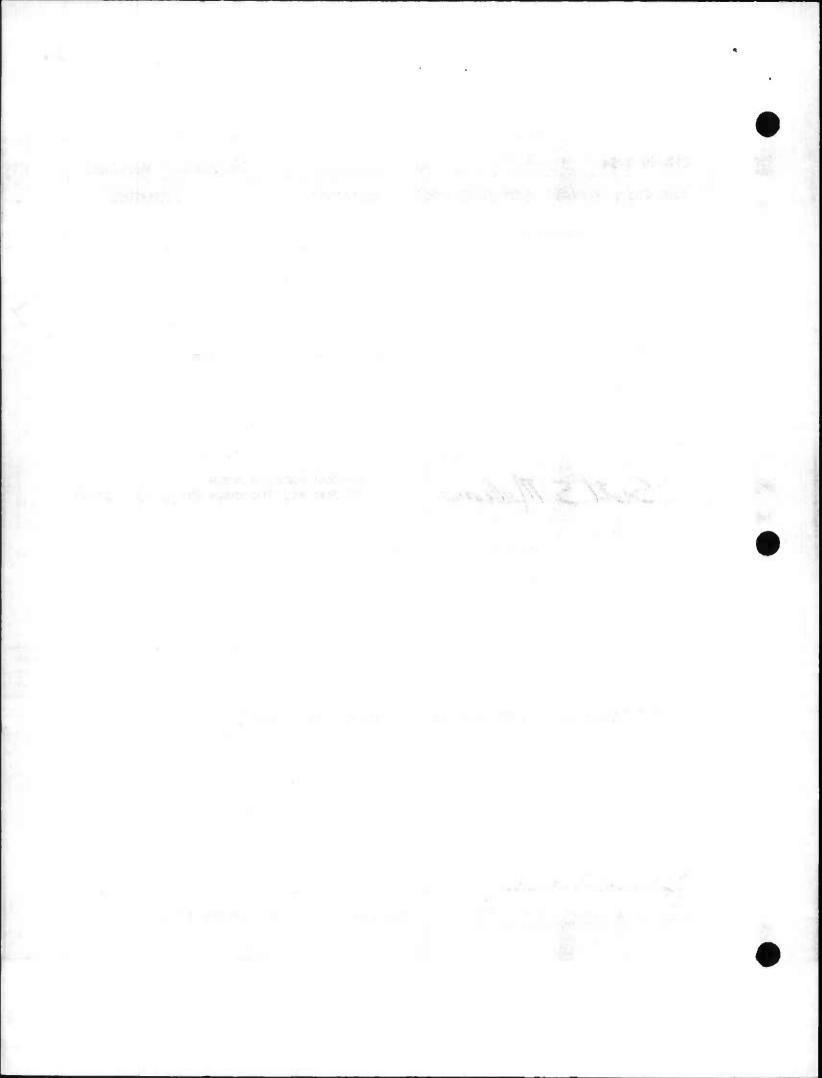
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYL REGISTRAR		TMENT OF H		MENTAL HYGIENE		0 1000			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH 3. TIME OF DEATH					
- 8	DONALD LEE JONES				NOV. 3	4:30 P. M				
		(in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRT	HPLACE (State or Foreign			
	213-24-0879 1½ M 2 🗆 F	67 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 06/23/28	Count				
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN (R LOCATION OF DE		9c. COUNTY OF D	aryland DEATH			
E C	422 S. Church Street		Sno	w Hill		Word	ester			
DIRECTOR	RESIDENCE OF DECEDENT									
2	10e. STATE 10b. COUNTY		Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?			
	Md. Worcester	S	now HI				1 X YES 2 □ NO			
M	10e. STREET AND NUMBER		101	. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL	422 S. Church Street			21863 U.S.A.						
F	11. MARITAL STATUS 1 □ Never Married 2 □ Merried FORCES? 1 ☑ YES	2 NO			C ORIGIN? (Specify Year, Puerto Rican, etc.)	or No- 14. RAC Blac	E — American Indian, k, White, atc.			
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR D	ATES	1 TYES	2 NO Specify.		Spec	white			
	15. DECEDENT'S EDUCATION	18a. DECEDENT'S	USUAL OCCUPATION	ON .	18b. KIND OF BUS	INESS/INDUSTRY	WILLEE			
COMPLETED	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5 +)	(Give kind of v	vork done during mo e retired.)	st of working						
립	11	Machin	ist		Weldir	ng/Mach	ine SHop			
S	17. FATHER'S NAME (First, Middle, Last)	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		16. MOTHER'S NAM	ME (First, Middle, Maiden S		Inc bhop			
BEC	Lee Franklin JOnes			Beulah	Mae Hast	ings J	ones			
	19a, INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street a	nd Number or Rural R	loute Number, City or Town	, State, Zip Code)				
임	Robert F. Jones	Box 4	7, Del	mar, De	laware 19	940				
		netery, crematory or of		me of	DATE 20c. LOC	ATION City or To	own, Stata			
- 1	4 Donetion 5 Other (Specify)	ates Ce	metery			w Hill	, Md.21863			
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	^		D ADDRESS OF FAC	eral Home	Homo				
	Falriciah Denn	5			7,Snow Hi		21863			
	23. PART I. Enter the diseases, or complications that caused	d the death. Do n	ot enter tha mo	da of dying, such	as cardiac or reapir	atory arreat,	Approximate			
Į	shock, or has t failura. List only one causa on a IMMEDIATE CAUSE (Final	ach lina.					Interval Between Onset and Daath			
	disease or condition a. CACHES DUE TO (OR AS A	VA 19	79.1				3 m15			
ľ										
2	Sequentially list conditions,	16GEM	- CAR	GINOMA	1 146.8		174MR			
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	CONSEQUENCE OF	7):							
일	CAUSE (Disease or injury	CONSEQUENCE OF								
	that initiated events resulting in death) LAST		,-				i i			
8	d									
A	PART II. Other significant conditions contributing to death b	ut not resulting I	n the undarlying	ceusa given in i	Part I. 24s. WAS AN A		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
음	ANEMIA 2189				1 YES 2	K NO	COMPLETION OF CAUSE OF DEATH?			
PHYSICIAN: MEDIC					_ '		1 - YES 2 - NO			
ÿ	DID TOBACCO USE CONTRIBUTE TO CAUSE O			UNCERTAIN						
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEAT	H (Check only one) OTHER:							
Z	1 YES 2 NO 1 Inpatient 2 ER/Outp		4 - Nursing Hom	5 Residence						
ᆸ	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI INJ	URY WO	RK?	26d. DESCRIBE HOW IN	JURY OCCURED				
m	2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY	- At home form a	M 1 1		And I CONTION (O	-11				
	3 Suicide 6 Could not be 4 Homicide detarmined	offy)	nieet, rectory, orner	·	28f. LOCATION (Street er City or Town, State)	o Number of Hurai I	Houte Number,			
	29a. CERTIFIER		Sold In the Control			ar and a second				
COMPLE	(Check only one) 2 MEDICAL EXAMINER: On the beat of my know medical examiner in the beat of my know one)									
	29b. SIGNATURE AND TITLE OF CERTIFIER		n, m my opinion, d							
8	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM		29d. DATE SIGNED				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH /ITEM 27 /3	Print	0-3	060	11-7-	73			
	Robert C. LaMar, M. D., 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGN	ATLIDE	-	Snor	w Hill, M	ID_2186	3.			
7	NOV 0 7 1995 Juliosen	Hon-Rondel	4							
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EDITION TO DESCRIPTIVE MARKET IN THE PROPERTY OF THE PROPERTY		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH											TIME OF DEATH	
2 18 - 20 - 3.394 1.5 to 19 - 20 1.5 to 2			ECIL	T.	JC	OHNSO	N						- 1	1310 ™
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D.M.F. D03599 30(Name and address of person who completed claise of death (item 27) (Typo, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND 21801 31. Date Filed (Month, Day, War) 32. REGISTRAR'S SIGNATURE	, H	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICE	NSE NUN	BER		29d. DATE S	IGNED (M	onth, Day, Year)
JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND 21801 31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE		John 56- July	melis	M.D				_D03	599			10-	26-9	5
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YEAR

1995

9c. COUNTY OF DEATH

Allegany

USA

10g, CITIZEN OF WHAT COUNTRY?

Specify: white

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

YES 2 NO

Approximate

interval Betwe

Onset and Death

year

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

OF GEATH? 1 YES 2 NO

Nov.

21502

COMPLETION OF CAUSE

MD

3:35

AM

2. DATE OF DEATH

November

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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31. DATE FILED (Month, Day, Year)

NOV 0 7 1995

4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morith, Day, Year) Oct 22, IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 X 57 217-66-9207 YRS. 1938 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Memorial Hospital Cumberland RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Allegany Cumberland permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE frer death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit 12111 Orabell Drive, NE 21502 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2X NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 □ YES 2 NO Specify: 1 Never Married 2 X Married BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION

1020 blind of work done during most of working ETED. 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 12 Housekeeper Thomas B. Finan Center 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) 듁 John William Twigg BE Ora Bell (Wertz) notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Donald J. Johnson Orabell Drive, NE: Cumberland, MD pe 20a. METHOD OF DISPOSITION

2 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must Donation 5 - Other (Specify) Restlawn Memorial Gardens 11/06 LaVale, MD medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY executed within 24 hours after death. Scarpelli Funeral Home fames Cumberland, MD 21502 completely filled in by the rial, cremation, or removal. 23. PART I/Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Fine)** the diseese or condition telic OUE TO (OR AS A CONSEQUENCE OF): traumatic event. resulting in death) burial. CERTIFICATION and Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING attending physician å law requires that the death certificate other CAUSE (Disease or injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 0 Mental shows any injury, the PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL has been signed by t Dept. of Health and 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) r this certificate ho item HOSPITAL OTHER: ATTENDING PHYSICIAN: 1 TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Residence 8 - Other (Specify) 10 27. MANNEB-OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. OESCRIBE HOW INJURY OCCURED 1 Natural м 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 60 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 28 4 Homicide Item 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 ho 2 MEDICAL EXAMINER: On the basis of examingsion and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE D 28910 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

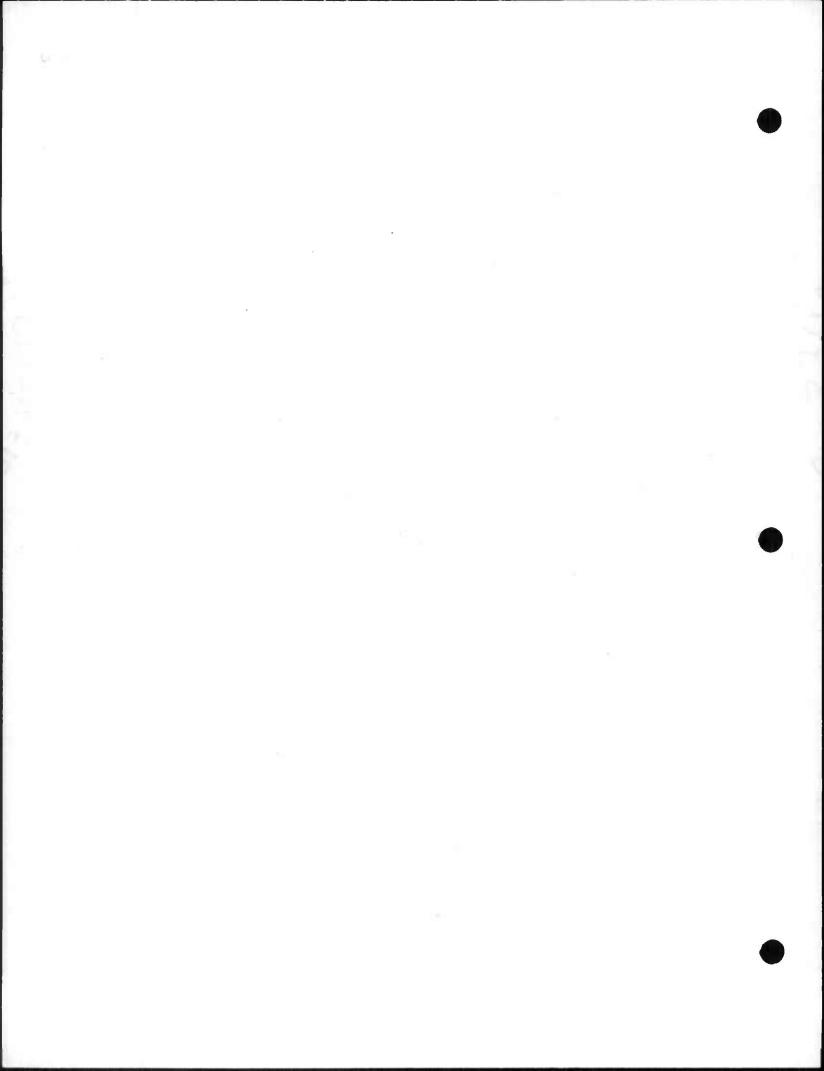
Dr. HC Merrick, Memorial Hospital Medical Bldg., Cumberland, MD

32 REGISTRAR'S, SIGNATURE
Julia Davidson Royal

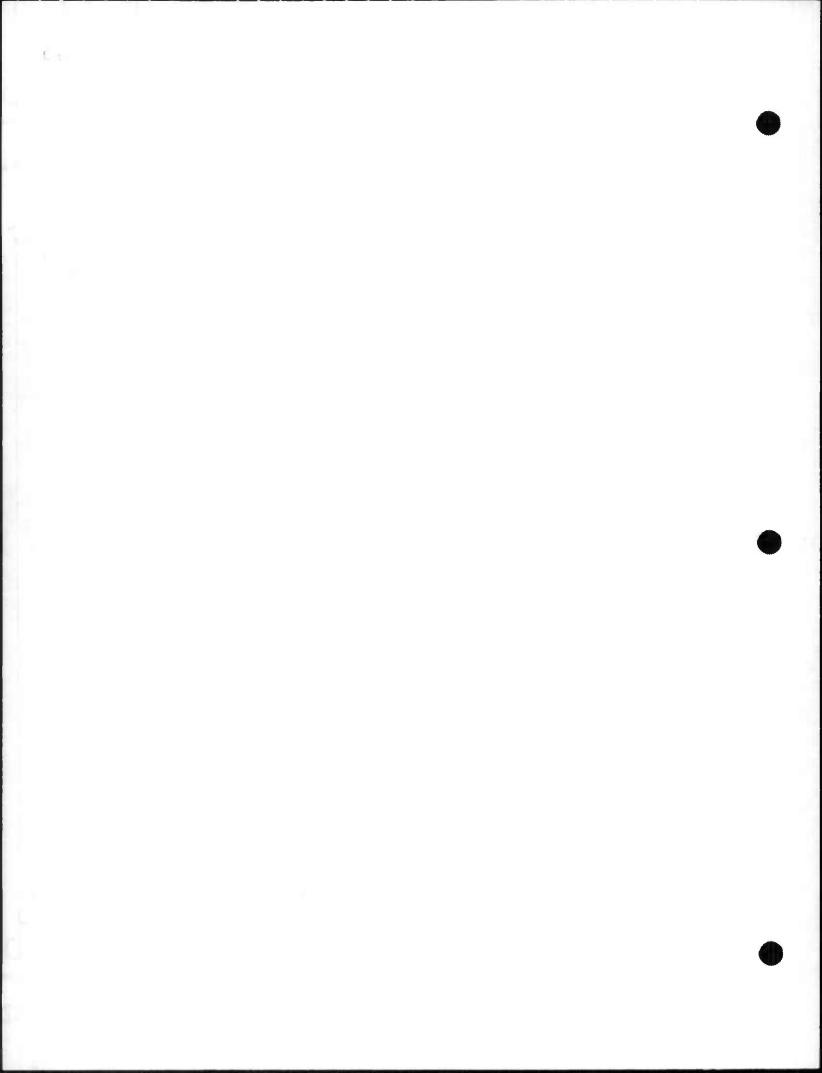
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

JOHNSON

29d. DATE SIGNED (Morth, Day, Year) 1995



		nedioman				CENT	IFICAL	E OF	DEA	П	_	REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH ORGIE PEACHIE JOHNSON														
											OCT 30 1995			5 : 4	40P "	
		4. SOCIAL SECURITY NUMBER	_	5. SEX		n yrs. lest birthd	MONTHS	DAYS	IF UNDER	MIN.	7. DATE OF (Month, L	BIRTH Day, Year)	1	B. BIRTHPL/ Country)	ACE (State of	or Foreign
<u> </u>		219-56-9373		1 🗌 M 2 💢 F	89	YR	3.				Jan 1	906	06 WV			
pinous	~	9a. FACILITY NAME (If not in	stitution, give s	treet and number)					OR LOCATI				9c. COUNT	Y OF DEAT	н	
ري دي	OR	GRANTSYLL		ONITE NU	IRSIN	G HOME	GR	ANTS	VILLI	43			GAR	RETT		
S.	DIRECTO	RESIDENCE OF DEC	100	CITY, TOWN	OR LOCA	TION					1 40	d. INSIDE	OUTV			
Pages	E	MD	A11e	egany			umber								LIMITS?	
permit.		10e, STREET AND NUMBER		gary			unber		f. ZIP COD	_			Lan orres	EN OF WHA	YES 2	****
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JZO physician. burial-transit	N.	Rte 8 Box	II C ADMED	140												
DZO physician. burial-trar		11. MARITAL STATUS 1 Never Married 2 X Married 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT					13.	If yee, sp	pecify Cube	n, Mexica	NIC ORIGIN? (on, Puerto Ric	specify tea en, etc.)	or No-	4. RACE — Black, W		Indian,
	B	3 Widowed 4 Divo	becau	IF YES, GIVE V	WH OH DA	IES		1 YES	2 (XNO	Specif	y.			Specify:	nite	
e as	8	15. DEC	EDENT'S EDU	CATION		18a. DECEDEN	T'S USUAL C	CCUPATI	ON		16b. K	ND OF BUS	SINESS/INDU		ш.се	
212 al or att for use		Elementary/Secondary (6	y highest grade 0-12)	College (1-4 or 5	+)	(Give kind life. Do NO	of work done T use retired.)	during me	ost of worki	ים						
NO NO NO NO NO NO NO NO NO NO NO NO NO N	귤	12				Home	naker					own H	ome			
the hospital or attending a detached for use as the tonce.	COMPL	17. FATHER'S NAME (First, M	liddle, Last)				-		18. MOT	HER'S NA	ME (First, Mid	dle, Maiden	Sumame)			
2 E E	BE	Miles La	ambert						E	liza	abeth	(Carr	c)			
maky retained by 5 should b notified a	B	19a. INFORMANT'S NAME (1	ype/Print)			19b. MAIL	NO ADDRES	S (Street			Route Number,	_ •		Code)		
63 61		Walter O.	Johnso	on		Rout	e 8 Bo	ox 2	41	/alle	ey RD;	Cumb	perlar	nd. M	21	1502
. Page 6 may be ral director, page 6		20e-METHOD OF DISPOSIT		and farm State	20b.	PLACE AND DA	TEOF DISPO	SITION (N	ame of		OATE		CATION — CI			
Page 6 ma al director, p		4 Donation 5 Other		over from State	- St	unset l	or other place. Temori	lal 1	Park		11/0	2 Cur	mberla	and,	MD	
Pag in a di		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE		11	22.	NAME A	ND ADDRE							
after death. Page 6 m after death. Page 6 m by the funeral director, moval. Ilcal examiner must		Scarpelli Funeral Home Cumberland, MD 21502														
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hours after bed in by the or remove		ehock, pr h	eert fellure.	List only one ceu	iee on ea	ch line.	O Hot ente	A A	ode Di dy	ing, suc	n as cerule	or respi	ratory srre	BT,	Approx	i Between
F 9 #		IMMEDIATE CAUSE (Fine) disease or condition														
owithin 24 ompletely fille I, cremation, event, the		resulting in death) e. Due to (orkis a consequence of):														
B P - 8		Sequentially the specifican To Arthroschustic Vascular Discase 5 years														
and and hart	RTIFICATION	OUE TO OR AS A CONSEQUENCE OF											1cars			
or to	¥	if any, leading to immediate cause. Enter UNDERLYING														
	필	CAUSE (Disease or inju that initieted events	injury & c.										-			
	E	resulting in death) LAST														
deatl afte ental	8															
T the the	Ä	e /)			deeth bu	it not resulti	not resulting in the underlying ceuse given in Pa						Part I. 24a. WAS AN AUTOPSY 24b. PERFORMED?			Y FINDINGS
) = 2 = E	EDICAL	Incumo									t	YES 2	DNO		MPLETION (OF CAUSE
requires been sign of Healt	Σ	previous		T1<01<										1 [YES 2	□ NO
has been Dept. of 1	AN:	DID TOBACCO U		RIBUTE TO CA				_		ERTAI	N 🗆					
e at e	SICI	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	2	6. PLACE OF D	CE OF DEATH (Check only one) OTHER:									
SICIAN: The Certificate the State	ı ≻ ı	1 TYES 2 NO		1 Inputient 2	ER/Outpe	rtlent 3 🗆 DO	4 N Nu	rsing Hon	ne 5 🗆 Re	sidence	6 Other (S	pecify)				
PHYSICIAN: this certifical with the St riked, or It	표	27. MANNER OF OEATH	D 41	28e. DATE OF (Month, D		28b.	TIME OF	28c. IN.	JURY AT ORK?		28d. DEŞCR	IBE HOW IN	NJURY OCCU	REO		
DING PHYS After this death with	β		Pending Investigation				M		YES 2	NO				_		
ATTENDING ECTOR: After s after death	ED		Could not be	28e. PLACE O building,	F INJURY - atc. (Specif	- At home, ter	n, atreet, tec	tory, offic	18		28t. LOCATI City or	ON (Street a: fown, State)	nd Number or	Rural Route	Number,	
DR ATTENDING DIRECTOR: After hours after death tem 28 is ma			aeterininea													
	7	(Check only	IFYING PHYSIC	CIAN: To the best of	my knowle	edge, death occ	urred at the	time, date	end place.	and dua	to the cause	s) and men	ner es stated	1.		
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COMPLET	one) 2 MEOI	CAL EXAMINE	R: On the beals of a	xamination	and Investig	ntion In my	opinion, d	leath occur	ed at the	time, date en	d place, and	d due to the	ceuse(a) an	d manner (ne stated.
E FU	u l	296. SIGNATURE AND TITLE	OF CERTIFIER	(1)	1	/ (/		29c. LICE	NSE NUN	WBER	T	29d. DATE S	SIGNEO (Mo	inth, Day, Y	bar)
TO THE HOSPIT TO THE FUNERA DE filed within 7	00	10	- 8	1)	X		IM		D	34	079		>Oc			995
ا ا	유	Dr. James	PERSON WH	COMPLETED CAU	SE OF DEA	TH (ITEM 27)	rpa Print)	L		0 1/	m 211	36			_ (113
NA	1	DI. James	pertze	T; DOLSE	y not	TET KOS	u; GI	ants	ハナナナ	e, M	كا كا:	536				
100		31. DATE FILED (Month, Day,	Year)	PA SEGISTRA	R'S SIGNA	PORE	-									
	ı	NOV 03	1995	Julia dow	il-Konton	Nandall										

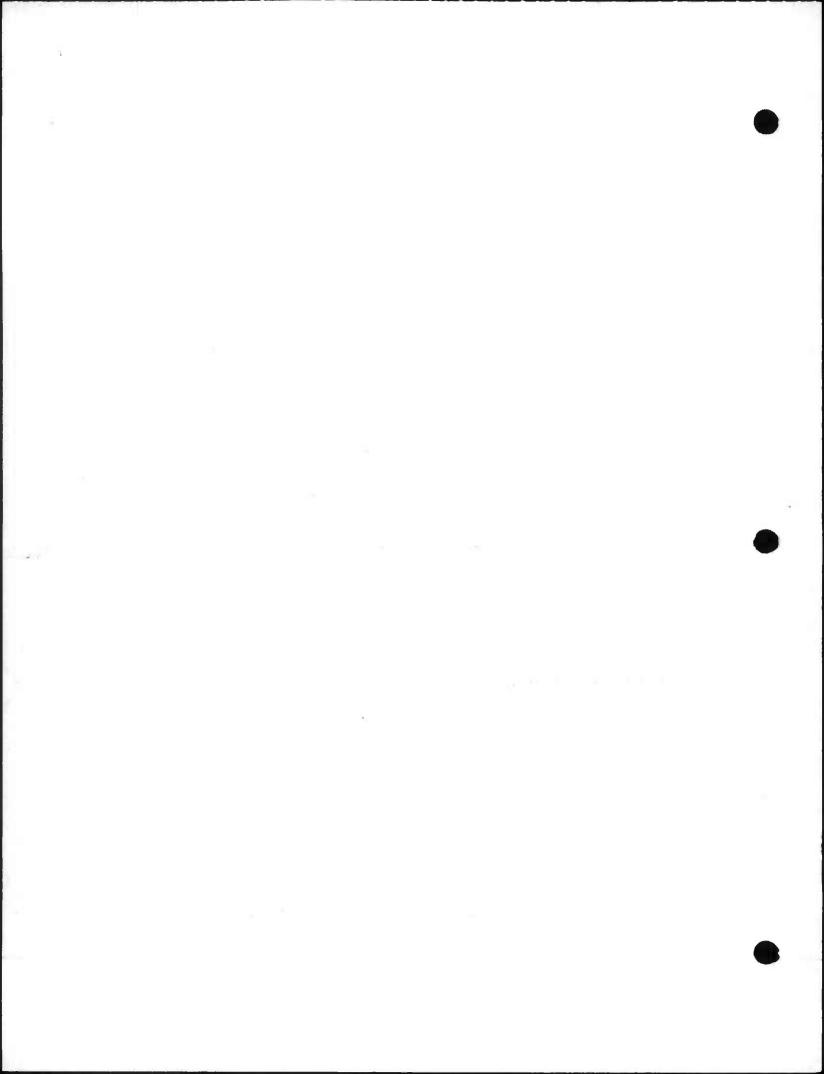


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO BE COMPLETED BY DUVELOIAN. MEDICAL SERVICE.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		MENTAL HYGIEN		
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	AY YE	3. TIME OF DEATH
	William Fr					Nov 4,	1995	2:25 P M
	4. SOCIAL SECURITY NUMBER 173-18-1823	1XXM 2 □ F 72	YRS.	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec 31,		BIRTHPLACE (State or Foreign Country) Pennsylvania
OR	99. FACILITY NAME (If not institution, give str Carroll County Ge	,			tminster		9c. COUNTY	of death YYOll
ECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		Inc CITY	TOWN OR LOCAL	TON			10d. INSIDE CITY
DIRECTOR	7	roll		Hamps	tead			1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 1024 Highfield Dr	ive		101	21074	1		OF WHAT COUNTRY? USA
B≺	11. MARITAL STATUS 1 Never Married 2 XMerried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 X YES IF YES, GIVE WAR OR DATE WW	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuben, Mexica 2 X NO Specif	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		RACE American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementery/Secondery (0-12)	completed) College (1-4 or 5 +)	ille. Do NOT use	rk done during ma retired.)	st of working	16b. KIND OF BU		
MP	12		Retail Fo	od Manage			er's & Gr	auls
BE CO	17. FATHER'S NAME (First, Middle, Last) Albert Kermes, Sr	•			Johann	ME (First, Middle, Meiden 1a Holup		
07	190. INFORMANT'S NAME (Type/Print) Edith Ann Kermes					Aoute Number, City or Tov Hampstead		
	20e. METHOD OF DISPOSITION 1	val from State 20b. PL	ACE AND DATE OF	emation	me of	1	ampstea	
	21. SIGNATURE OF FUNERAL SERVICE LICE	J. Elm	e		Main S	Eline St, Hampste	Funera ead, MD	
	23. PART i. Enter the diseases, or co shock, or heart fellure. L	omplications that caused the let only one cause on each	ne deeth. Do no n line.	t enter the mo	de of dying, auc	h ea cardlec or reep	iratory arrest,	Approximate Interval Between
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	ACUTE MY			ARCTION	1		Onset end Death
NO	Sequentially list conditions,	DUE TO (OR AS A CO						
ICATI	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CO						
CERTIFICATION	that initieted events resulting in death) LAST d.							
AL C	PART II. Other significent conditions	contributing to deeth but	not resulting in	the underlying	ceuse given in			24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA	HYPERTENSION	CARDIOVASCU	LAR DI	SEASE		PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
N.	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	DE NO E	UNCERTAI	N 🗆		
CA		HOSPITAL:	PLACE OF DEATH	(Check only one)				
14S	1 YES 2 1 NO 27. MANNER OF DEATH	1 Inpatient 2 SER/Outpatie		☐ Nursing Hom		8 🗆 Other (Specify)		
	1 Natural 5 Pending	(Month, Day, Year)	INJUI	RY WO	PES 2 NO	28d. DEŞCRIBE HOW	NJURY OCCURE	:D
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, str	eet, factory, office		28f. LOCATION (Street City or Town, State,	end Number or Ri	ural Route Number,
COMPLETED	29e. CERTIFIER (Check only	IAN: To the best of my knowledg	je, death occurred	at the time, date	end place, end due	to the cause(s) end me	nner ee stated.	-
NO.		On the besie of examination er						use(s) end menner ee stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI		29d. DATE SIG	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO		(ITEM 27) (Type P	rint)	11/40	1	1/	0/91
		USTINO, M.D.			AMPSTE	AD, MD 210	74	
	31. DATE FILED (Month, Day, Year) NOV 7 1995	32. REGISTRAR'S SIGNATU	Redall					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mofts after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEP	ARTMENT O	F HEALTH AN	ID MEI	NTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)	Edna		Kra	mer	2.	DATE OF DEATH	MY	YEAR 5	3. TIME OF	DEATH 2	N.
		4. SOCIAL SECURITY NUMBER 181 03 5092A	1 □ M 2 □X0= 9	(In yrs. lest birthde	MONTHS DA	YS HOURS M	™. Se	DATE OF BIRTH (Month, Day, Vers) PLETIDER 2	7 1902	BIRTH Countr	PLACE (States)	e or Foreign	1
	CTOR	9a. FACILITY NAME (If not institution, give Calvert County Nursing RESIDENCE OF DECEDENT				Frederick			Calve		EATH		
	DIREC	10a. STATE 10b. COUNT		10c.	CITY, TOWN OR L	OCATION				$\overline{}$	10d. INSID	E CITY	_
			e Georges	Hy	attsville	2					1 YES		
	FUNERAL	100. STREET AND NUMBER 4905 70th Place				101. ZIP CODE 20784			1		THAT COUNTY		
	IND:	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS	DECENDENT OF HI	SPANIC O	RIGIN? (Specify Ya		4. RACE	- America		_
	ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		It yes	, specify Cuban, M.	exicen, Pu pecify:	iario Rican, atc.)		Black	white, atc.		
		15. DECEDENT'S EDU	ICATION	18e. DECEDENT	T'S USUAL OCCU	ATION		16b. KIND OF BU	SINESS/INDI		WILL	-	_
	COMPLETED	(Specify only highest grade	College (1-4 or 5+)		of work done during use retired.)	most of working				31111			
ice.	JMP	17. FATHER'S NAME (First, Middle, Last)		hous	ewife			own hon					
at Or		Alvin Savage				Cate M		First, Middle, Maiden	Sumame)				
tified	TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILI	NG ADDRESS (Str	et and Number or R	tural Route	Number, City or Tow	n, State, Zip C	code)			_
pe no		Naomi E. MIller		4905 7	70th Place	Hyattsvi	lle M	20784					
must		20e, METHOD OF DISPOSITION 1	oval from State	PLACE AND DAT	r other place!	xender 4,	1995	DATE 20c. LO	cation — ci andria				
examiner must be notified at once.		21. SIGNATURE OF FUNERAL BERRYCE LIK	CENSEE	\		E AND ADDRESS O		Rausch F					
lical		23. PART i. Enter the diseases, or	complications that caused	the death, De		Broomes Is							_
other traumatic event, the medical		shock, or heart failure. iMMEDIATE CAUSE (Final disease or condition reaulting in deeth)	Liet only one ceuse on e	ach line.		^					Onse	oximate rai Betwe t and De	
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othe	RTIFICATION	thet initiated events resulting in daeth) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):								
Iry, or	Ü		d										
hows any l	MEDICAL	PART II. Other algnificant condition	a contributing to death be	ut not recuiting	g in the underl	ying cause given	In Part	i. 24a. WAS AN PERFOR	MED?		WERE AUTOR AMILABLE P COMPLETION OF DEATH? 1 YES	RIOR TO	
23	AN	25. WAS CASE REFERRED TO MEDICAL											
r item	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpi	atient 3 □ DOA	OTHER:	PLACE OF DEATH					-		_
	품	27. MANNER OF DEATH	26s. DATE OF INJURY (Month, Day, Year)	28b. T		INJURY AT WORK7		DESCRIBE HOW II	NJURY OCCU	RED	-		_
	à	1 Netural 5 Pending			M 1	YES 2 NO							
788	E	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Speci	— At home, term	, street, factory, o	ffice	281.	LOCATION (Street a City or Town, State)	and Number or	Rural Ro	oute Number,		
MPORTANT: If item	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE	CIAN: To the best of my knowle R: On the basis of examination	edge, death occu	rred at the time, o	late end place, end	due to the	cause(a) and men	ner as stated		and many		
RTAN		29b. SIGNATURE AND TITLE OF CERTIFIES		Cando	0	,29c. LICENSE			29d. DATE S				_
MPC	10 BE	AT Meurs	- IVID -77	Elyn	I	D19	94	27	> 1	11	3	55	-
		30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Ty)	oe, Print)							-	-
		31. DATE FILED (Month, Day, Year) NOV - 7 1995	32. REGISTRAR'S SIGNA	ATURE									_
	Į.	140 A _ / 1344	A MAN CO COMPANY.	" WE WIND									

Pages 1, 2, 3;

permit.

use as the burial-transit

page 5 should be detached for

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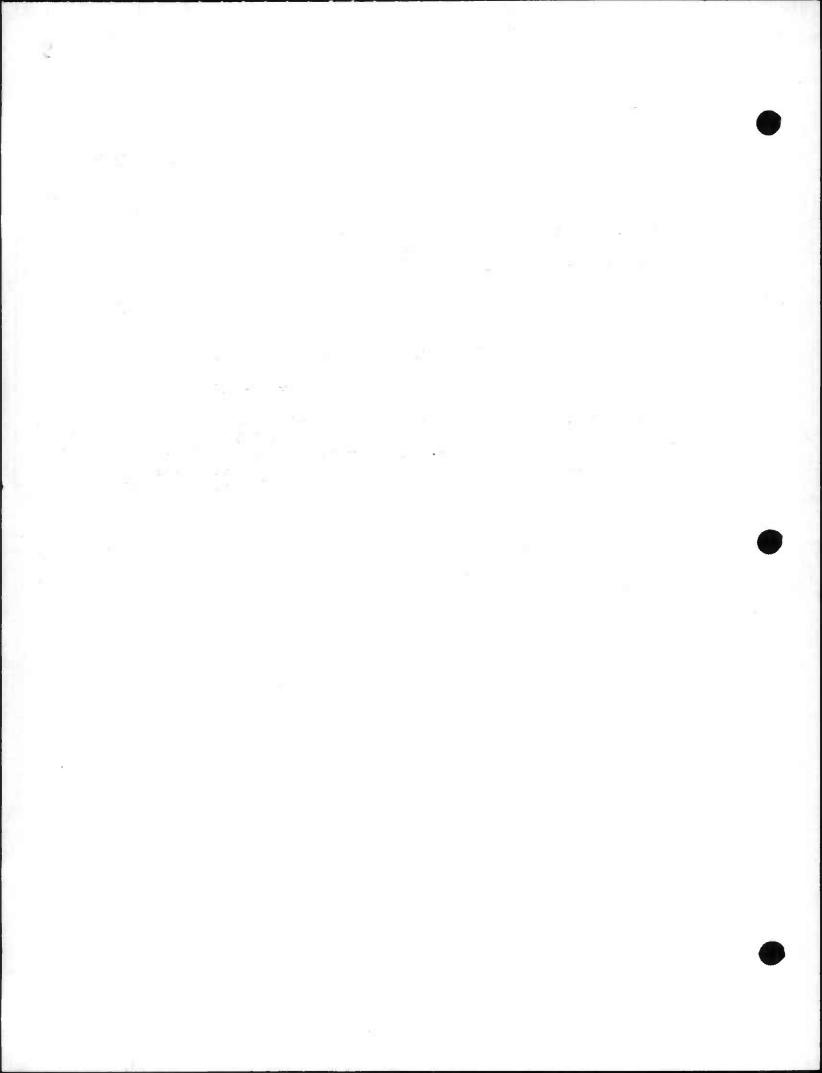
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BALL	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pr	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examine
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DIVISION OF VITAL RECORDS, P.O. BOA 88/80	SIAN	he S	10
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5	TEN	DB.	60
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	PITA	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	T. If
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH Sarah Jane Knight November 5, 1995 9:45 P M 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8, BIRTHPLACE (State or Foreign 223-56-2104 1 M 2 TYF 53 May 6, 1942 Virginia 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Southern Maryland Hospital Center Clinton. Prince George's RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Upper Marlboro 1 TYES TO NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 17228 Brook Meadow Lane 20772 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 ☐ YES 2 ☐ No Specify: BY 3 Widowed 4 Divorced Black ETED. 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Telephone Operator C& P Telephone 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 Robert White BE Joanna Hill 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charlie Knight Brook Meadow Lane, Upper Marlboro, Md 20772 pe 20a, METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Nam NOV 9, 1995) ATE 20c. LOCATION — City or Town, Stata must. metery, cremetory or other place)
Maryland Veterans Cemetery Cheltenham, Maryland 4 Donation_5 Other (Specify) examiner 21. SIGHATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 2073\$ medical 23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart fellure. List only one ceuse on each line interval Between **IMMEDIATE CAUSE (Fine)** Onset end Death diseese or condition 華 CARDIORESPIRATORY resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF). * ASPIRATION traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 9 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any CORONARY ARTERY DISEASE, LIVER FAILURE 1 - YES 2 - NO SARCOIDOSIS, DUE ESRA DIABETES DELLITO TO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN T ICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: PHYSI 1 - YES 2 NO Inpatient 2 - ER/Oulpatient 3 - DOA 4 Nursing Home 5 Raeldenca 8 Other (Specify) 6 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCUREO marked, 1 X Natural 5 Pending M BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, larm, streat, lactory, office building, atc. (Specify) 89 ETED 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 28 determined Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, end due to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MID. 16116 OK D ▶682 Nov. 1995 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print).

32. REGISTRAR'S SIGNATURE

Fillia d'Aurelian-Randall



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flowers after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAH		ENTIF	CALE OF	DEALL	REG. NO).	
	1. DECEDENT'S NAME (First, Middle, Last)		i				MY YE	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SE			NE			5 9	
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 1 UNDER 1 YEAR 1 UNDER 24 HRS. 7. DATE OF BIRTY (Morth, Day, Year) 9. 4. OC+ 18 19. 19.33							Country)
	9a. FACILITY NAME (If not institution, give street an			9b. CITY, TOWN	OR LOCATION OF DI		9c. COUNTY	OF DEATH
DIRECTOR	7051 CATTO 11 A VE-	Apt 602		TAK	MA PA	3415	Prince	Georges
H H	10a. STATE 10b. COUNTY	`		TOWH OR LOCA	LION			10d. INSIDE CITY LIMITS?
	MD Prince	george's	TA	KOMA	PARIC			1 TES 2 NO
FUNERAL	7051 CArroll	Ave # 6	,02	101	2 0 9 /	2	10g. CITIZEN	OF WHAT COUNTRY?
5	11. MARITAL STATUS 12. W	AS DECEDENT EVER IN U.S. A	RMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Ya	a or No- 14.	RACE — American Indian, Black, White, etc.
B		FYES, GIVE WAR OR DATES	NO		ecify Cuban, Maxica 2 NO Specif	n, Puerlo Rican, etc.) y:		Specify: Black
0	15. DECEDENT'S EDUCATION (Specify only highest grade comple		ECEDENT'S L	JSUAL OCCUPATION done during mo	ON	16b. KIND OF BU	SINESS/INDUST	RY
COMPLET			e. Do NOT use	retired.)	at or working	Uns	5, 60	ry1+
OM	17. FATNER'S NAME (First, Middle, Lest)				18. MOTNER'S NA	ME (First, Middle, Maider		
BE C	William Sutto	oh					ooke	
TO B	19a. INFORMANT'S NAME (Type/Print)	11	Db. MAILING	ADDRESS (Street a	and Number or Rural	Route Number, City or Tov	vn, State, Zip Cod	(0)
F	Avant Massenbur	79	7/2 E	· Andrew	is Ave	, Henders	かかつ	27536
	26a. METHOD OF DISPOSITION 1 Pairial 2 Cremation 3 Removal in 4 Donation 5 Other (Specify)		ematory or oth	FDISPOSITION (Na per place) Emokia	Gardey	10/22 11	harrs - city	(a C
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE				ND ADDRESS OF FA	CILITY	(0.	
	Nelson E D	hure J.				814 Fr	E FUNERA Inklin Stre dria. VA 2	et 2314
	23. PART i. Enter the diseeses, or compli shock, or haert failure. List or	icetions that caused the d	eeth. Do no	ot enter the mo	da of dying, auc	h aa cerdiac or reep	iratory arrest,	Approximata interval Between
	IMMEDIATE CAUSE (Final		•		0			Onset and Death
	disease or condition resulting in death)	Drug		suer o	Lose			16hs.
		DUE TO (OR AS A CONS	IQUENCE OF)	:				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE OF)	*				
8	cause. Entar UNDERLYING CAUSE (Disease or injury							
E	that initiated events	DUE TO (OR AS A CONSE	QUENCE OF)					
H	resulting in death) LAST							
	PART II. Other algnificant conditions conf	tributing to deeth but not	reculting in	the underlying	g causa given in	Part I. 24a, WAS AN		24b. WERE AUTOPSY FINDINGS
EDICAL						PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED								OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTRIBUT	TE TO CAUSE OF DEA	ATH YES	O NO [UNCERTAIN	v 🗆		
N S	25. WAS CASE REFERRED TO MEDICAL	28. PLA	CE OF DEATH	(Check only one)				
Sic	l nos	SPITAL: Inpetient 2 - ER/Outpetient :	DOA	OTHER: 4 Nursing Nom	5 Residence	8 Other (Specify)		
PHYSICIAN:		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		URY AT	28d. DESCRIBE HOW	NJURY OCCURE	D
Æ	1 Netural 5 Pending 2 Accident Investigation				ES 2 NO			
COMPLETED	3 Succide 8 Could not be 4 Nomicide determined	28a. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, at	reet, lactory, offic	.	281. LOCATION (Street City or Town, State)		ural Route Number,
PE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: T	To the best of my knowledge, de	eath occurred	at the time, data	and place, and dua	to the cause(a) and me	nner ea stated.	
NO.	one) 2 MEDICAL EXAMINER: On I							use(a) and menner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN			NED (Month, Day, Year)
0	De Oa	· La	2		208	1458	100	T 25 95
임	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEATH (ITE				(7)	Bet	hooden rel.
	001~	aubor	8	3518	ا تعادی	consin	4 4	OP
	31. DATE FILED (Month, Day, Year) OCT 31 1995	PREGISTIAN'S SIGNATURE	dell					

Actor No.

TO BE COMPLETED BY FUNERAL DIRECTOR

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DIVISION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buntal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Dr. Mokhtar Nasir
31. DATE FILED (Month, Day, Year)

NOV 8 1995

8 1995

1 - FOR STATE REGISTRAR	STATE OF		/ DEPART					MENTAL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF OEATH		YEAR	3. TIME OF DEATH
RUTH EVELYN KI	RKENDAL	L						NOV. 5, 19	95	YEAR	9:30 Pm
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER 1 Y	EAR	IF UNDER 24 H	IRS.	7. DATE OF BIRTH			IPLACE (State or Foreign
218-28-0192	1 🗌 M 2 😓 F	6.3	YRS.	ONTHS D	AYS	HOURS M	NN.	(Month, Day, Year) March 10,	1932	Countr M >	ryland
90. FACILITY NAME (If not institution, give	street and number)			9b. CITY. TO	O MWC	R LOCATION (OF DE			NTY OF D	
			1								
Carroll County Ge	eneral Hos	spital		W	est	minste	er			Carr	OTT
10e. STATE 10b. COUN	TY		t0c. CITY,	TOWN OR	LOCAT	ION					10d. INSIDE CITY
Maryland (Carroll		l We	stmi	ns	ter					LIMITS?
10e. STREET AND NUMBER					101.	ZIP CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?
49 Liberty Str	-eet					2115	57		IIn	itad	States
11. MARITAL STATUS	12. WAS DECEDE	NT EVER IN U.S. A	ARMED	13. WA	S DEC			NIC ORIGIN? (Specify Yes			E – American Indian,
1 Never Married 2 Merried	FORCES?	YES 2X		If y	es, spe	ecify Cuben, N	Aexica	in, Puerto Ricen, etc.)	0. 110	Black	k, White, efc.
3 Widowed 4 Divorced	IF YES, GIVE	WAR OR DATES		'-	YES	2 <u>₩</u> NO 3	Specify	y:	. 15	Spec	hite
15. DECEDENT'S ED	UCATION	16a, I	DECEDENT'S U	SUAL OCCI	JPATIO	ON		16b, KIND OF BUS	INESS/IN		nre
(Specify only highest gre	de completed)		(Give kind of wo	retired.)	ing mos	st of working					
Elementary/Secondary (0-12)	College (1-4 or 5	+)		emak				Do	mes	+ic	
17. FATHER'S NAME (First, Middle, Last)			поп	remak	er		10 414	ME (First, Middle, Maiden		LIC	
Charles Willia	m Wito							Me (First, Middle, Malden Becker	aumame)		
	иш птсе										6
t9a. INFORMANT'S NAME (Type/Print)								Route Number, City or Tow			21150
Patricia G. Ki	rkendal	1 /	12 W1	nasc	r	DEIVE	= ,	Westmins			
20e. METHOD OF DISPOSITION **DESCRIPTION** **Properties**: The control of the c	moval from State		EAND DATE OF					19A7-10 20c. LO	CATION —	City or To	own, State
4 Donation 5 Other (Specify)		_ Dular	ney Va.	Lley	Men	norial	Gā	ardens] _{Ba}	1ti	more	, Marylan
21. SIGNATURE OF FUNERAL SERVICE	Zlabo	Hill	LUON	Мує	ers		era	al Home treet, We	actm	inet	er, MD
23. PART I. Enter the diseasea, o shock, or heart fellure	r complications the call to th	et church the duse on each li	death Do no								Approximata interval Between
IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. left	lowe-	lobe	ç	كالنوا	UMOU	ż				3 there
	b	O (OR AS A CONS	SEOUENCE OF)								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	O (OR AS A CONS	EOUENCE OF)								
CAUSE (Disease or Injury	c. DUE TO	O (OR AS A CONS	EQUENCE OF)	:							
that initieted events reaulting in deeth) LAST		`									
	d						_				+
PART II. Other algorificent conditions Acute Revail			t reculting in	the unde	erlylng	g ceuee give	en In	Part I. 24a. WAS AN PERFOR	MED?	248	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
											1 TES 2 NO
DID TOBACCO USE CON	TRIBUTE TO CA	AUSE OF DE	ATH YES	S N	0 [UNCER	RTAI	N 🖭			
25. WAS CASE REFERRED TO MEDICAL			ACE OF DEATH								
EXAMINER?	HOSPITAL:	EP/Outnotlant		OTHER:	- 14			a [] orb(0(4)			
27. MANNER OF DEATH	28e. DATE O		28b. TIME		_	URY AT	нпсе	8 Other (Specify) 28d. DESCRIBE HOW I	N.IIIPV C	CUBED	
1 Netural 5 Pending		Day, Year)	INJU	IRY	WO	RK?	10	230. DEGUNIDE NOW	HOURT OC	CONED	
2 Accident Investigation		OE IN HIDY	home 4-			YES 2 N	10	004 1 0 0 0 7 10 11 12			0
3 Suicide 8 Could not be determined	• building	OF INJURY — At J. etc. (Specify)	nome, rerm, at	reat, tectory	y, orfice	•		281, LOCATION (Street City or Town, State)	ana Numbe	w or Hurai	noute Number,
29e. CERTIFIER					_			L			
(Check only								to the cause(s) end me			
2 MEDICAL EXAMI	MER: Un the beels of	exemination end/	or investigation	i, in my opli	nion, d	eath occured	at the	time, date end place, er	d due to t	he ceuse(s) end menner es stated.
296. SIGNATURE AND TITLE OF CERTIF	IER M	0				29c. LICENS					(Month, Day, Year)
30. NAME AND ADDRESS OF PERSON N	VHO COMPLETED CA	USE OF DEATH (I	TEM 27) (Type,	Print)		2797	, ,			, -	1 44

r 295 Stoner Avenue, Westminster,
32. REGISTRAR'S SIGNATURE
Julia Davidson Realest

MD

21157

BALTIMORE, MARYLAND 21215-0020 tet death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 6876

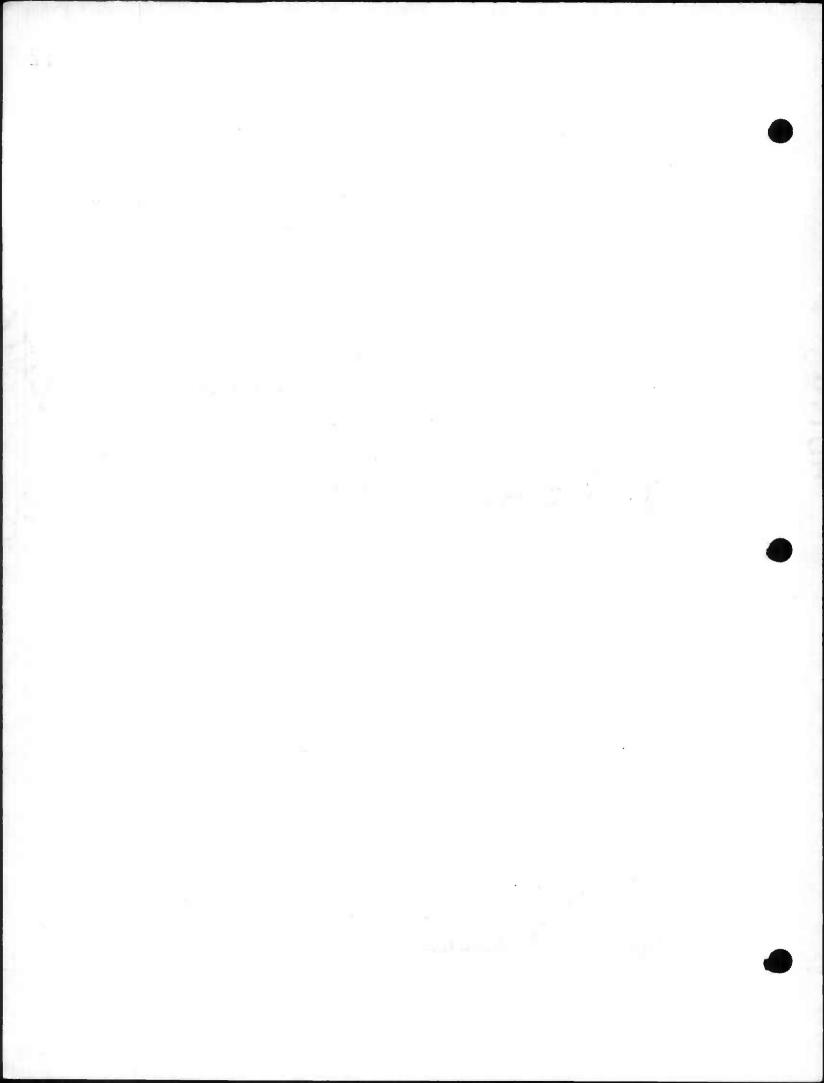
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withm 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the funeral physician and completely filled in by the funeral director, page 5 should be detached the complete of the funeral director.	be life when 12 hours are dean will he sake dept. Or regulation hereal signer provide comment, or removal. IMPORTANT: If them 28 is marked, or frem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,
ours after death. Page 6 m	In by the funeral director,	nedical examiner mus
e be executed within 24 h	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the testing completely filled in by the second control of the complete of the party of the complete of	traumatic event, the
s that the death certifical	gned by the attending phy	s any injury, or other
IYSICIAN: The law require	is certificate has been significate the Court of He	ed, or item 23 shows
ITAL OR ATTENDING PH	RAL DIRECTOR: After this	If item 28 is marke
THE HOSP	TO THE FUNE	IMPORTANT

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)

i	1. DECEDENT'S NAME (First	, Middle, Last)							2. DATE OF DEAT	H DAY	VEAR	3. TIME OF DEATH
ľ	Jeremiah		dy						Oct. 24		YEAR	11:00 a M
4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest b						IF UNDER	DAY8	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Ye	ı	8, BIRTH Countr	IPLACE (State or Foreign
į	218-30-1022		1 X M 2 - F	8	4 YRS.	MONTHS	DATE	HOURS MIN.	May 12,			aryland
,	Se. FACILITY NAME (If not in					9b. CITY	, TOWN	OR LOCATION OF DE	EATH	9c. CO	UNTY OF D	EATN
DIRECTOR	Center P	ark Ap	ts. Apt.	#24		Ce	ntre	eville)ueen	Annes
i ii	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN (OR LOCA	TION				10d. INSIDE CITY
5	Maryland	Quee	n Annes		Ce	ntre	vill	e				LIMITS?
A I	10e. STREET AND NUMBER							H. ZIP CODE		10g. C	TIZEN OF V	WHAT COUNTRY?
	Center P	ark Ap	ts. Apt.	#24				21617			USA	
FUNERAL	11. MARITAL STATUS	100007	12. WAS DECEDEN					CENDENT OF HISPAN			14. RACI	E — American Indien, k, White, atc.
BY	1 Never Married 2 3 X Widowed 4 Divo		IF YES, GIVE Y					S 2 X NO Specifi		•,	Spec	w Black
- 11	15. DEC	EDENT'S EDUC	CATION	164	. DECEDENT'S	USUAL O	CCHPATI	ION	165 KIND O	BUSINESS/II	MULIETON	
COMPLETED		ly highest grade				work done	during m	ost of working	1000 10110 0	DOG!!!EGG!!		
릴	6th	- 12,	Contago (1-4 of 3	"		Farme	er			Far	ming	
충	17. FATNER'S NAME (First, M								ME (First, Middle, M			
BE	Jeremiah	Kenne	dy					Ann	ie Deato	n		
0	19e. INFORMANT'S NAME (.,						end Number or Rural I				
	Bernard		у			_		. Centre				
	t XBurial 2 Cremetic	on 3 🗆 Remo	oval from State	20b. PLA	CE AND DATE	of DISPOS	FICTOR	ale Cent.	10/28/95	D. mana		
	21. SIGNATURE OF FUNERA		ENSEE	Date	.ic.ici. i			IND ADDRESS OF FA	CILITY	DULLI	SVII	re, MD
į.	> (a)	10		15				e Smith				
	23. PART-I. Enter the d	M. O	muel		tout 0			Box 1687				
	ehock, or h	eert fellure.	List only one ce	use on each	line.	not enter	the m	ode of dying, suc	n es cerdisc or	espiratory (errest,	Approximate Interval Between
	IMMEDIATE CAUSE (Fit disease or condition	nal		,		6.4						Onset and Death
ł	resulting in death)	7	B. DUE TO	(OR AS A CO	NSEQUENCE O	F):	1					1 4
z			b.									
CERTIFICATION	Sequentially list condit if any, leading to imme	diate	DUE TO	(OR AS A CO	NSEOUENCE O	F):						
<u> </u>	cause. Enter UNDERLY CAUSE (Disease or Inju		C. DUE TO	(OR AS A CO	NECOUENCE O	D.						
	thet initieted events resulting in death) LAS	т	DOE TO	OH AS A CO	NSEQUENCE O	**}:						
			d				-					
AL	PART II. Other significe	ent condition	s contributing to	death but n	not resulting	In the u	nderlylr	ng ceuse given in		S AN AUTOPS	Y 246	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL									1 🗆 Y	S 2 NO		COMPLETION OF CAUSE OF DEATH?
Σ∥												1 TYES 2 NO
ä	DID TOBACCO U		RIBUTE TO CA		PLACE OF DEA	ES 🅦			и Ц			
HYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	IU MEDICAL	HOSPITAL:			OTHE	R:			<u> </u>		
Ş }	1 YES 2 NO		1 Inpatient 2		M 3 DOA		_	JURY AT	8 Other (Specify 28d. DESCRIBE I		CCURED	
۵.		Pending Investigation	(Month, I	Day, Year)		JURY	W	ORK? YES 2 NO			.0001125	
BY	2 Accident 3 Suicide 8	Could not be	28e. PLACE (OF INJURY — A	At home, ferm,	street, fac	tory, offi	ca	281. LOCATION (S	treet and Numi	per or Rural	Route Number,
MPLETED	4 Nomicide	datarmined	bulloting	, etc. (Specify)					City or Town,	State)		
	29e. CERTIFIER (Check only	TIFYING PNYSI	CIAN: To the best o	f my knowledg	e, death occur	ed at the t	time, dat	e end place, and due	to the ceuse(e) en	menner ee s	tated,	
COM	and and											s) and manner ee stated.
шШ	296. SIGNATURE NO YOU	OF CHTIFIE	2					29c. LICENSE NUI	MBER	29d. D	ATE SIGNED	(Month, Day, Year)
<u>۵</u> ∥	70	Ani	www.)				030	703 C	•	rel	1/2/
2	30. NAME AND ADDRESS 9	PE SON WN	O COMPLETED CAL	ISE OF DEATN		, Print)	1 6	1 1 4	1	0	.1	W X6/9
	اناه	~	200	se		8 0	011	Woods 1	Mue	ne	ship	M X6/9
	31. DATE FILED (Month, Day,			AR'S SIGNATU								
	NOV 01	1995	falsa do he	poliar Ra	white.							



CERTIFICATE OF DEATH

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burial-transit Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 page 5 should be detached for use as the the funeral director, hours after death. removal and completely filled in by burial, cremation, or remo 2 physician prior Hygiene the attending p signed by the certificate has been h the State Dept. of · this c DIRECTOR: After the hours after death v 98 FUNERAL | within 72 h TO THE HOSPITA
TO THE FUNERA
DE filed within 7.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN NOVEMBER 4, 12:17AM M RONALD GRANT KNIPPLE 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign AUG 30 1927 215 26 6575 DAYS HOURS 1 X M 2 - F 68 "MARYLAND YRS. 9a. FACILITY NAME (If not Institution, give street and number 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATN CUMBERLAND MEMORIAL HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY CUMBERLAND ᅙ 1 YES 24TNO 10a STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? RFD#8 BOX# 423 (BOWMANS ADDITION) 21502 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 € NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, etc. tf yea, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify:WHITE 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gr (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COCA COLA BOTTLING CO. SUPERVISOR 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Meiden Surname GRANT KNIPPLE BERNICE MAE KEPLINGER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 21502 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata ↑ XBurlel 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) ROSE HILL CEMETERY NOV 7 1995 CUMBERLAND MARYLAND 21, SIGNATURE OF FUNERAL SERVICE LICENT 22. NAME AND ADDRESS OF FACILITY
MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 23. PART I. Enter the dieesees, or compilicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert fellure. List only one ceuse on each line. interval Between Onset and Deeth IMMEDIATE CAUSE (Final disease or condition Cardiorespiratory arrest resulting in deeth) 15 mins. DUE TO (OR AS A CONSEQUENCE OF End stage chronic obstructive pulmonary disease 10 years Sequentielly liet conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL OTHER: t YES 2 NO 1 | Inpatient 2 | ER/Outpatien 3. DOA 4 - Nursing Nome 5 Residence 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 286. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES BY Investigation 2 Accident 28a. PLACE OF tNJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide COMPLET 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day Jear) BE NOV-6-95 C 2377 rece 00 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) URIEL VELANDIA 924 SETON DRIVE CUMBERLAND, MARYLAND 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 07 1995

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TO BE COMPLETED BY FUNERAL DIRECTOR
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	upp	IMPORTANT: It liem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1. DECEDENT'S NAME (First, Middle, L.	est)							2. DATE OF MONTH	DEATH DA	NY .	YEAR	3. TIME OF DEATH
WILDA MABEL	KESNER					1		OCTO		8, 1		4:30 p
4. SOCIAL SECURITY NUMBER		3. AGE (In yrs. las		IF UNDER	1 YEAR DAYS	HOURS	MIN.	7. DATE OF (Month, D	lay, Ybar)		S. BIRTI	HPLACE (State or Foreign try)
235-52-5324	1 🗆 M 2 💢 F	84	YRS.					March	24	1911	WV	
9a. FACILITY NAME (If not Institution, g	ive street and number)			9b. CITY		OR LOCATI		EATH			INTY OF	
Sacred Heart Ho	spital				Cun	berl	and			A	lleg	any
RESIDENCE OF DECEDENT			1									
10e. STATE 10b. CO			10c. CIT	Y, TOWN C								10d. INSIDE CITY LIMITS?
WV	Mineral			Ke	eyse	r						1 TYES 2 X NO
10e. STREET AND NUMBER					10	. ZIP COD	E			10g. CI1	TIZEN OF	WHAT COUNTRY?
HC 72 Box	140					2	6726	,		U.	S.A.	
11. MARITAL STATUS 1 Never Merried 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI	YES 2 XI			f yes, ap		n, Mexico	NIC ORIGIN? (an, Puerto Rice ty:		or No-	14. RAC Blac Spec	E — American Indian, sk, White, etc. city: White
15. DECEDENT'S (Specify only highest)		16a. DE	CEDENT'S	Work done	CCUPATI	ON ast of worki	inca.	16b. K	ND OF BUS	SINESS/IN	DUSTRY	164
Elementary/Secondary (0-12)	College (1-4 or 5+)	life	. Do NOT u	make		JOI DI WORK	,,,,		Own	Hom	e	
17. FATHER'S NAME (First, Middle, Last)					18. MOT	HER'S NA	AME (First, Mid	dle, Maiden	Surname)		
George Eston	Dolly					Ma	ry	Ellen	Wei	mer		
19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES!	S (Street	and Numbe	r or Rural	Route Number,	City or Tow	n, State, Z	ip Code)	
Eldridge C. Kes	ner	l H	IC 72	Bo	x 14	0	Ke	evser.	WV	267	26	
20a. METHOD OF DISPOSITION		20b. PLACE	_		ITION /N	ama of		DATE	20c. LO	CATION -	- City or T	own, State
t X Buriet 2 Cremetion 3 4 Donation 5 Other (Specify)	Removal from State	Du Lin				10/3	1/19			yser		26726
21, SIGNATURE OF PUMERAL SERVICE	W LINGWICE	Duran	g dei			ND ADDRE			I KC.	ysci	, ", "	20720
7/1	1)	1/						Fune	ral H	ome		
1	C. VA	- /									r. W	V 26726
23. PART I. Enter the diseases,	or complications that	ceused the de	eeth. Do									Approximate
shock, or heer fell IMMEDIATE CAUSE (Finel disease or condition	ure. List only one ceus	OVEY	ledw	Mark		(er	Sis					Onset and Dec
resulting in death)	DUE TO (OR AS A CONSE	ONENCE C	OF)))) 1		1 1					10110
	_	ana	ton	inta		bres	ra	duo.	,			136 how
Sequentielly list conditione,	b. DUE TO (OR AS A CONSE	4	9. /		01 0						1 3
if sny, leading to immediate cause. Enter UNDERLYING		mal	nut	+17	6h							(pmont)
CAUSE (Disease or Injury that Initiated events	C. DUE TO (C	OR AS A CONSE	QUENCE (OF):	7	_	3/	1	T :A:			
resulting in death) LAST	A-901	1	o contract	0 0.	tral	mte	tin	1 4	least.	C dear		L upara
resulting in death) LAST		1 10 10 1		N 17 J	7 1 72 V				JAN DI	V July V		Acres of
readiting in death, LAST	d	IONE		Jas	1100	01.10	3 (11	107	July	XPUX		800-

tailure YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH

1 YES 2 NO

COMPLETION OF CAUSE OF DEATH? 1 TES ZENO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one)

HOSPITAL: 8 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED

28c. INJURY AT WORK?
1 YES 2 NO 28e. PLACE OF INJURY —

29c. LICENSE NUMBER 296. SIGNATURE AND TITLE OF CEN 29d. DATE SIGNED (Month, Day, Year)

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

21502 Cumberland, MD

Roy Chishom, 31. DATE FILED (Month, Day, Year)
NOV 0 6 1995

6 Could not be determined

27. MANNER OF DEATH

1 Netural 2 Accident

3 Sulcide

4 Homicide 29a. CERTIFIER

32. REGISTRAR'S SIGNATURE

924 Seton Drive

DHMH-18 Rev 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX DOX.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.

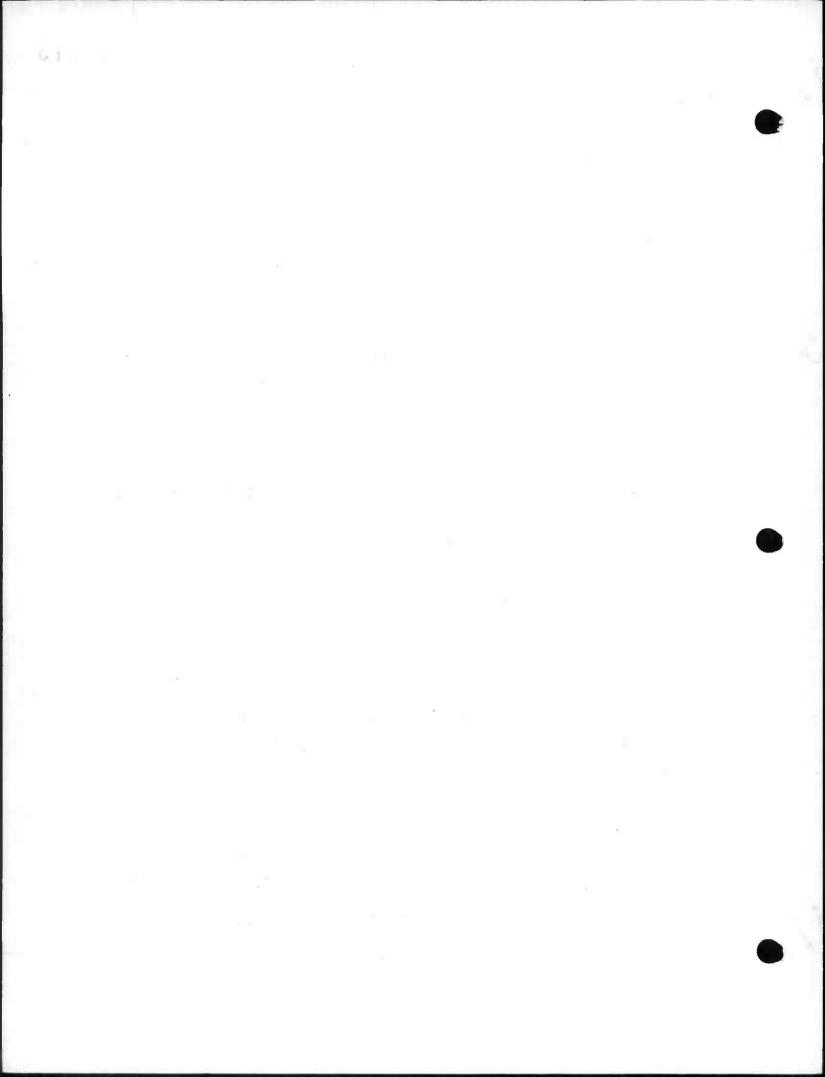
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

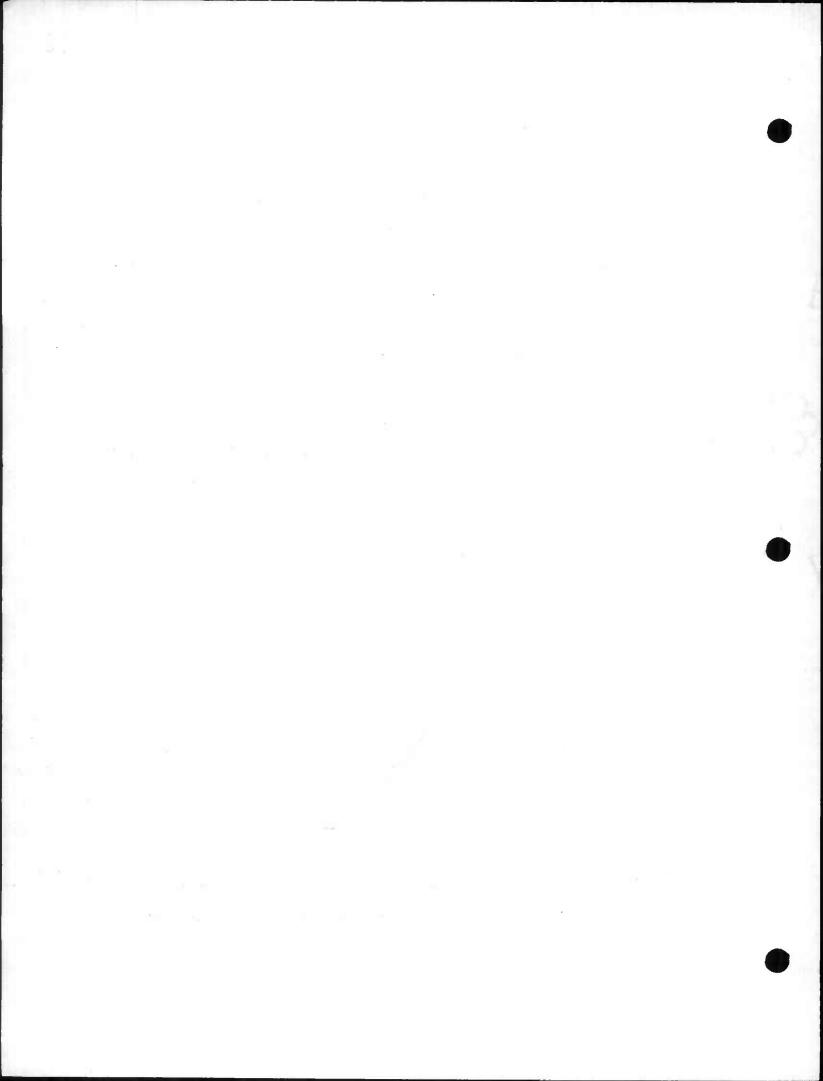
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	1. DECEDENT'S NAME (First Ronald	CRAI	G	K1a	vuhn					MONTH	ber 31		YEAR	3. TIME OF OEATH 8:05 A	
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs	last birthday)	IF UNDER 1	YEAR	IF UNDER	24 HIRS		OF BIRTH	, 17		IPLACE (State or Foreign	\exists
	214-36-6692		1 [XM 2 □ F	57	YRS.		DAYS	HOURS	MIN.	(Month	, Day, Year)		Count	γ)	
	9e. FACILITY NAME (If not in		at OFFW	9b. CITY, TOWN OR LOCATION OF GEATH 9b. CITY, TOWN OR LOCATION OF GEATH					MARYLAND	4					
œ	628 YALE S					ON OF CE	ATH								
2	RESIDENCE OF DEC					CUMBERLAND ALLEGANY									
2	10e. STATE	10c. CIT	Y, TOWN OF	LOCAT	ION						10d. INSIDE CITY	Н			
DIRECTOR	MARYLAND	ALL	EGANY		CI	MBERI	LAND)						LIMITS?	1
	10e. STREET AND NUMBER						101	. ZIP CODI	F			10a CIT	TIZEN OF Y	WHAT COUNTRY?	Н
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B	3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DATES		'	YES	2 × NO	Specify	<i>/</i> :			Speci	"y:white	
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립	10				TROEHM	IANS I	BAKE	ERIES		M	ECHANI	C/Br	read	CO	
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)						18. MOTI	HER'S NAI	ME (First, M	liddle, Maiden	Sumame)			7
	DANIEL MA	TTHEW	KLAVUHN					ORL	EANA	EDW.	ARDS	,			
BE	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street e	nd Number	or Rural F	Route Numb	er, City or Town	. State. Zit	to Code)		٦
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H	reaulting in death)	→	l	(OR AS A COA	03/6	150	Cl	1000	Me	- 01	ling			6 Km7	4
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BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injuthat Initiated events resulting in death) LAS PART II. Other eignification of the control of the cause of	D USE CO MEDICAL Pending Investigation Could not be datermined ITIFYING PHYSIC ICAL EXAMINER F PERSON WHILE (ANJITH Year)	DUE TO B contributing to CIAN: To the best of a contributing. CIAN: To the best of a contribution. CIAN: To the best of a contribution. CIAN: To the best of a contribution.	death but not be a considered to the considered	USE OF 26b. Till IN. t home, farm, do investigate (ITEM 27) (Type	DEATH OTHER: 4 Nursil BURY M atrast, factor at the tim on, in my op	28. PL :: :: :: :: :: :: :: :: :: :: :: :: ::	ACE OF D S Re URY AT RK? FES 2 end place, eath occur 29c. LICE	NO EATH (Che esidence No No and due red at the	261, LOCACINY of the cause to the cause time, data	PERFOR 1 YES 2 (Specify) CRIBE HOW IP ATION (Street a per Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or or Rural F	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,	



DIVISION OF VITAL RECORDS, P.O. BOX 6876(BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a ther HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTAL HYGIENE						
	1. OECEDENT'S NAME (First, Middle, Lest) JOSEPH	THOMAS		ANZI		2. DATE OF GEATH DAY DBER 28,	1995	3. TIME OF DEATH 3:55 A M				
	4. SOCIAL SECURITY NUMBER	T T		UNDER I YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		HPLACE (State or Foreign				
	217-60-0681	1 X M 2 D F	37 YRS. MON	THS DAYS	HOURS MIN.	(Month, Day, Year) May 15, 19	Count	th Carolina				
	9a. FACILITY NAME (If not institution, give s	street and number)	9b.	CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF					
DIRECTOR	ROUTE #213, 5M	ROUTE #213. SMILE SOUTH OF ROUTE #310 CHESAPEAKE CITY CECIL										
Ä	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.											
5	Maryland Cec	ryland Cecil Elkton										
ERAL	100. STREET AND NUMBER 21 Sheryl Drive	21921		10g. CITIZEN OF U.S.A	WHAT COUNTRY?							
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D.	2 X NO	I1 yes, sp		IIC ORIGIN? (Specify Year on, Puerto Rican, etc.)	or No — 14. RAC Blac Spec	E — American Indian, ik, White, atc.				
COMPLETED	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	ICATION o completed) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during mo		16b. KIND OF BUSI						
MP		3½	Trooper			Maryland	State	Police				
00	17. FATHER'S NAME (First, Middle, Last)	nh C I			10. MOTHER'S NA	ME (First, Middle, Maiden S						
BE (eph G. Lanzi				Patricia						
TO E	19a. INFORMANT'S NAME (Type/Print) Lisa L. Lanzi					Route Number, City or Town, .kton, MD 2						
	20a. METHOD OF DISPOSITION 1X Burlal 2 Cremetion 3 Ram 4 Donation 5 Other (Specify)	noval from State Cen	PLACE AND DATE OF DI netery, cremetory or other maculate	sposition (Na place)	ion Cem.	10°431 20c. LOC.	ATION — City or T	own, State				
	21, SIGNATURE OF FUNERAL SERVICE LI			22. NAME A	ND ADDRESS OF FA	CILITY						
	Donald	S. His	a D			r Funerals, on St., Elk		21921-5521				
	23. PART i. Enter the diseases, or	complications that caused List only one cause on a						Approximeta Interval Between				
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. MULTIPLE	E INJURIE	S				Onset and Death				
CERTIFICATION	Sequentielly liet conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL	PART II. Other algnificent condition	ns contributing to deeth b	out not resulting in the	ne underiyin	g ceuse given in	Part I, 24a. WAS AN A PERFORM 1 X YES 2	AED?	b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
Σ	DID TOBACCO USE CONT	RIBLITE TO CALISE O	DE DEATH VEC		LINCEDTAI	NI		N YES 2 □ NO				
A	25. WAS CASE REFERRED TO MEDICAL	T CAUSE C	26. PLACE OF DEATH (
200	EXAMINER?	HOSPITAL;	netient 2 7004	HER:	a d D B ald an	e X Other (Specify) R	0101111					
HX8	27. MANNER OF DEATH	200. DATE OF INJURY	26b. TIME O		JURY AT							
	1 Natural 5 Pending	(Month, Day, Year) 10/28/199	95 3:40A		YES 2 NO	DRIVER O		THAT STRU				
ВУ	XX Accident Investigation 3 Suicide e Could not be	28e. PLACE OF INJURY	/ - At home, farm, stree			28f. LOCATION (Street ar	OBJECT nd Number or Rural	Route Number,				
	4 Homicide detarminad	building, atc. (Spe	ROADWAY	7		ROVTE: \$#2 #310 CE	13 SOU					
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my know			and place and du			UNIY, MaDa				
MP		ER: On the beals of examination						(a) and manner as stated.				
	200. SECHABURE AND TITLE OF CERTIFIE	$-\alpha$	(/)/		29c. LICENSE NU			D (Month, Day, Year)				
TO BE	Human	Down	M		O.C.M			8, 1995				
	MARIO F. GOLL	E M.D.	111 Penn		et, Ba	ltimore, l	Maryla	nd 21				
	31. DATE FILED (Month, Day, Year) NOV 0 2 1995	July Dawdior Ra	Mall Mall									



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiens prior to burial, cremation, or removal.

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STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH AND	MENTAL HYGIENI
	CERTIFICATE	OF DEATH	REG. NO.

	FOR STATE REGISTRAR		STATE OF MARY		DEPARTMENT DEPARTMENT			MENTAL HYGIEI			
	1. DECEDENT'S NAME (First	t, Middle, Last)	OHADIMY D					2. DATE OF DEATH	DAY		3. TIME OF DEATH
		CHARIT	CHARITY BY LANDRU		LANDRUM	1		OCT OBER27		995	07:10 AM
	4. SOCIAL SECURITY NUME	BER		(In yrs. la		UNDER : YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	PLACE (State or Foreign
	250-16-5637			87	YRS.		OR LOCATION OF DE	OCTOBER			TH CAROLINA
DIRECTOR		PRINCE GEORGE'S COMMUNITY HOSPITAL CHEVERLY							4		GEORGE'S
<u>ا</u> يو	10e. STATE	10b. COUNTY			10c. CITY, TO	OWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
	MARYLAND 100. STREET AND NUMBER		E GEORGE'S	UPPI	R MARI	L ZIP CODE		1		1-YES 2 NO	
FUNERAL	11907 WIMBL		TREET			10	20772	2		S.A.	VHAT COUNTRY?
	11. MARITAL STATUS 1 Never Married 2	Mandad	12. WAS DECEDENT EVER FORCES? 1 YES					NIC ORIGIN? (Specify Ya	s or No-	14. RACE Black	— American Indian, c, White, alc.
BY	3 Widowed 4 Divo		IF YES, GIVE WAR OR				2 NO Specifi			Speci	
ED		CEDENT'S EDUC		16a. DE	ECEDENT'S USL	JAL OCCUPATE	X ON	16b, KIND OF BU	JSINESS/INC	DUSTRY	BLACK
E	(Specify online Elementary/Secondary (Control of the Control of th	ly highest grade 0-121	College (1-4 or 5+)	life (C	Give kind of work b. Do NOT use re	done during mo tired.)	est of working	2333300			
됩	6th				DOMI	ESTIC		SELF			
COMPL	17. FATHER'S NAME (First, M	Aiddle, Last)					18. MOTHER'S NA	ME (First, Middle, Maide	n Sumame)		
BE	CHARLIE SIM						LIZZII	E OLITHANT	- <u>-</u>		
2	JOSEPH SIMP							Route Number, City or To ET: UPPER			MD. 20772
	20a. METHOD OF DISPOSIT	TION	2	Db. PLACE	ANDDATEOFD	ISPOSITION (N			OCATION —		
	1 Burial 2 Compation 4 Donation 5 Gother	r (Specify)		PDEA:	emetory or other SANT GI	ROVE BA	APTIST 4	4NOV95 ED	GEFIE	ELD,	S.C.
	21. SIGNATEREDE BUNERA	A Barryice sic	FERMANA	D			ND ADDRESS OF FA		DAT 1	OME	TNC
	GLE	NDA M.	FREEMAN	T				NKINS FUNE			
	23. PART Enter the d	diseases, or c	omplications that ceus List only one cause on	ed the d	eeth. Do not	enter the mo	de of dying, auc	h as cardiac or rea	oiratory en	rest,	Approximate interval Between
ŀ	IMMEDIATE CAUSE (Fin					60.0			0 -		Onset and Daeth
	disease or condition	→	DUE TO (OR AS	A CONSE	COUENCE OF:	CAR	PIAL	INFA	KC T	101	N 10/25/9
_			SER-	TI	CF	MI	A				10/251
임	Sequantially list condit if any, leading to imme	diate	DUE TO (OR AS	A CONSE	OUENCE OF):		00.		4 .	1	13/90
CA	cause. Enter UNDERLY CAUSE (Disease or inju		CAR	DI	AC	/-	+KK	1717	111	7	10/25/
RTIFICATION	that initieted eventa resulting in death) LAS	т	DUE TO (OR AS	A CONSE	OUENCE OF):						13/9/
CE											
۸Ľ	PART II. Other aignifice	ent condition	a contributing to daeth	but not	resulting in t	he underlyin	g ceuse given in	Part i. 24a, WAS A	N AUTOPSY PRMED?	24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDIC			EPENPE				DEF	1 450 YES	XXNO		OF DEATH?
Σ	INFECT		DECUB RIBUTE TO CAUSE	OF DE		LCE	UNCERTAI				1 YES 2 NO
AN	25. WAS CASE REFERRED T		RIBUTE TO CAUSE		CE OF DEATH			N LJ			
HYSICIAN:	EXAMINER?	Ren	HOSPITAL:	itpatlant :		THER:	na 5 🗆 Raaldenca	8 Other (Specify)			
7) 10 10 10 10 10 10 10 1											
ВУР	1 Natural 5 2 Accident	Pending Investigation				M 1 🗆					
ED	3 Suicide 8 Homicide	Could not be determined	28e. PLACE OF INJUI building, atc. (Se	RY — At h	ome, farm, stree	et, factory, offic	:0	281. LOCATION (Street City or Town, State	and Number	r or Rurai i	Route Number,
		- Constitution									
29s. CERTIFIER (Check only one) 29s. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									s) and manner as stated.		
BE C	296. SIGNATURE AND TITLE	E OF CENTIFIES	han	101	MA		29c. LICENSE NU	MBER	29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS O	DE PERSON WHI	COMPLETED CAUSE OF	DEATH OT	M 27) (Sma Ori	nt)	11/10	108	/	0/	21195
	AROAL	4 /					rive Si	vite 22	2 Box	ue	ND,



As

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlat, cremation, or removal.

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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REGISTRAR			Ci	ERTIF	ICATE	OF	DEATH		REG. NO				
1. OECEOENT'S NAME (First,	Middle, Last)								OF DEATN			3. TIME OF DEA	TN
Mildred		I.	Lank	ford				MONT		2 1	995	4:49	A
4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. les		IF UNDER 1	YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	2 1.	-	NPLACE (State or F	-
214-32-5868		1 🗌 M 2 🔀 F	82	YRS.	MONTHS	DAYS	HOURS MIN.	OCT.	th, Day, Year)	913	Count	NSYLVANI	_
9e. FACILITY NAME (If not ins	titution, give st	reet end number)			9b. CITY.	TOWN C	OR LOCATION OF D		7, 1.		UNTY OF C		A
UNIVERSITY	OF MAR	YLAND HO	ςρτπΔī.		· ·		10RE					RE CITY	
RESIDENCE OF DEC		TEMP 110	OF LIVE		DA		TORE			DAL	LIMOI	KE CITI	
UNIVERSITY RESIDENCE OF DEC 10e. STATE MARYLAND	10b. COUNTY	,		10c, CIT	Y, TOWN OF	LOCAT	ION					10d. INSIDE CITY	Y
MARYLAND	DORC	HESTER		CAN	BRID	GE						LIMITS?	NO
									10a CC	TIZEN OF I	WHAT COUNTRY?	NO	
701 RACE ST	REET						21613			USA		MILLI COOMING	
10e. STREET AND NUMBER 701 RACE ST	1222	12. WAS DECEDENT	FVER IN II S AR	MED	T 12 W		ENDENT OF NISPA	100 00100	10.40 44.14				
	Married	FORCES? 1	YES 2 K	10	1 11	yes, sp	ecify Cuben, Mexic	en, Puerto	Rican, atc.)	or No—	Blac	E — American Indi k, White, atc.	an,
3 X Widowed 4 Divor	ced	IF YES, GIVE W	AH DH DATES		1	YES	2 X NO Speci	fy:			Spec	WHITE	
15. DECE	OENT'S EDUC	CATION	16a, DE	CEOENT'S	USUAL OC	CLIPATIO	NA .	161	. KINO OF BUS	CINEDO (IN	OUETRY	WILLIE	
(Specify only Elementary/Secondary (0-	highest grade		(Gi	Do NOT us	work done di	uring mo	st of working	100	KINO OF BU	3114E35/114	DUSTRI		
Elementary/secondary (U-	12)	College (1-4 or 5+)	,	ACHER				FI	LEMENTA	ADV (SCHOO)T	
15. DECE (Specify only Elementary/Secondary (0-	(dlo ast)		1111	ТОПЫ			18. MOTHER'S NA				301100)L	
									NSTABLI				
O INCOMMANDE NAME OF													
BONNIE WILL							nd Number or Rural					01/10	
BONNIE WILL							OUGH AVE	NUE,					
20e. METNOD DF DISPOSITION 1 X Burlel 2 Cremetton	3 🗆 Remo	val from State	20b. PLACE A cemetary, crei			TION (Na	me of	OAT			- City or To		
4 Donetion 5 Other		0/	EAST 1	VEW M	IARKE		EMETERY		4 EAS	r nev	W MAF	RKET, MD	
21. SIGNATURE OF FUNERAL	SERVICE LICI	ENSEE	111				D ADDRESS OF FA		Æ 10	C MA.	TN CE	DD FFF	
Revu	w	g de	les				R FUNERA						
23. PART I. Enter the dis	eases or c	omplications that	cattend the de	eth Do	T C	D. DC	OX 207,	EASI	NEW MA	AKKE.	I, MI	Approxim	_
iMMEDIATE CAUSE (Fine disease or condition reaulting in death)	hi → a	. Conge	Stive He	eart QUENCE O	Fail	ure						Onset and	d Death
if any, leading to immed cause. Enter UNDERLYIN CAUSE (Disease or injur	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated exercise). DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
that initiated events resulting in death) LAST	l d		OH AS A CONSEC	OENCE O	-):						-		9
	t conditions	contributing to	deeth but not re	esuiting i	in the und	leriying	ceuse given in	Part i.	24a. WAS AN		24b	. WERE AUTOPSY F	
PART II. Other significer Periphe:	cal Va	scular D	isease						PERFOR			AMAILABLE PRIOR COMPLETION DF	
									1 1 163 2	Mino		OF DEATH?	74
DID TOBACCO US	E CONTR	IRLITE TO CAL	ISE OF DEAT	TLI VI	C D N		LINICEDTAL					1 YES 2 1	NO
25. WAS CASE REFERRED TO		IBUTE TO CAL			N (Check or		UNCERIAL	M M					
EXAMINER?		HOSPITAL:			OTHER:	ny one;							
DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN		1 X Inpatient 2 🗆				_	5 - Residence						
1 Natural 5 P	ending	28s. DATE OF I (Month, De	NJURY y, Year)	28b. TIM INJ	E OF 2	WO	JRY AT RK?	28d. DES	CRIBE NOW II	NJURY OC	CURED		
	vestigation				М		ES 2 NO						
3 Suicide 8 C	ould not be etermined	28e. PLACE OF building, e	INJURY — At her rtc. (Specify)	me, term, s	street, factor	ry, office		28t. LOC City	ATION (Street e or Town, State)	and Numbe	or or Rural F	Route Number,	
		CIAN: To the best of r										i) end manner es s	tated.
III THE THE STREET WAS VITA	OF CERTIFYER	1 11	111		-	Т	29c. LICENSE NUI	MBER		29d DAT	LE SIGNED	(Month, Day, Year)	-
Code	H	Ma	11/	ly									OF
30. HAME AND ADDRESS OF	PERSON WHO	COMPLETED CALLED	F OF DEATH OTEN	1 27) /5-01	Drint)		D3286	0		IN	ovem	per 2 19	32
Security Marchine Control		. /						00 -	_				
Cedric She	risera	M.D.	univers:	ity c	oi MD	HOS	spital,	22 S	. Gree	ne S	t.,Ba	alt. 212	01
31. DATE FILED (Month, Day, M	7"1995	Salva auto	I'S SIGNATURE	dally									

BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Page		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit.	novai.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PHYSICIAN: MEDICAL CERTIFICATION

BY

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last. 2. DATE OF DEATH 3. TIME OF DEATH IO 74 Blanche E. Lankford 4:25 Рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birtnday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 5/3/1901 HOURS 1 M 2 X 1 213-10-3863 94 MD. YRS 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Caroline Nursing Home Denton, MD Caroline RESIDENCE OF DECEDENT 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. Caroline Federalsburg 1 - YES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Liberty Road 21632 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Ricen, atc.) 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried 1 TYES 2 NO Specify: 3 Widowed 4 Divorced BY Specify: White ETED 15. DECEDENT'S EDUCATION pecify only highest grade comple 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 0 Housewife Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Charles Meredith</u> BE <u>Lillie Mae Scott</u> 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Elizabeth L. Box 736, Glen Eco, MD 20812 20e. METHOD OF DISPOSITION

1 V Burlel 2 Cremetion 3 Removal from State
4 Donetton 5 Other Specific 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE emetery crematory or other place) Hillcrest Cemetery Donation 5 - Other (Specify) 10/18∤95 Federalsburg,MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Williamson Funeral Home Federalsburg, Md. 21632 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erreat, Approximata shock, or haart failure. List only one cause on each line. intarvai Betwe **IMMEDIATE CAUSE (Final** Oneat and Death allure disease or condition resulting in death) DUE TO JOR AS A umi Sequantially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO JOR AS A CONSEQUENCE OF that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE allon 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔼 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA rsing Home 5 Realdence 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO м Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, atreat, factory, office building, etc. (Specify) 3 Sulcida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AME THILE OF CONTRICES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Mont) JU NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

PO BOX

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0 1995

32, REGISTRAR'S SIGNATURE Julia Savelen Rardall

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1 - STATE REGISTRAR

		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
		1. DECEDENT'S NAME (First, Middle, Last) Gladys J.	Marshall	7.6			2. DATE OF DEATH MONTH DE	0 9	YEAR 3. TIME OF DEATH	
pir	DIRECTOR	4. SOCIAL SECURITY NUMBER 218-20-1137	1 □ M 2 🖔 F 7	yrs. lesi birthdey) 7 () YRS.	F UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) NOV. 21,19		B. BIRTHPLACE (State or Foreign Country) North Carolina	
2, 3 should		9a. FACILITY NAME (If not institution, give st Route 27 and Mt. RESIDENCE OF DECEDENT	· ·		Mt. Air	OR LOCATION OF DEA	тн	Sc. COUNT	Y OF DEATH	
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, moval. cal examiner must be notified at once.		10a. STATE 10b. COUNTY	tgomery		Y, TOWN OR LOCAT	TION			16d. INSIDE CITY LIMITS? 1 V YES 2 NO	
	IERAL	100. STREET AND NUMBER 26811 Ridge Road			101	20872		1 "	en of what country? ed States	
	LETED BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES		If yes, sp	ENDENT OF HISPANIC ecify Cuban, Mexican, 2 NO Specify:	ORIGIN? (Specify Year Puerto Ricen, etc.)		4. RACE — American Indian, Black, Whita, atc. Specify: White	
		15. DECEDENT'S EDUC (Specify only highest grade Elementery/Secondary (0-12)		18a. DECEDENT'S (Give kind of life. Do NOT u Homema k		ON asl of working	Own Hom		STRY	
	E COMPL	17. FATHER'S NAME (First, Middle, Last) James Ward		Tromema k		18. MOTHER'S NAM	E (First, Middle, Meiden Norris			
	TO B	19a. INFORMANT'S NAME (Type/Print) Paul E. Marshall	, Jr.			and Number or Rural Ro	ute Number, City or Town			
		20e, METHOD OF DISPOSITION 1	oval from State 20b. f	PLACEANDDATE	of Disposition (Na Disposition (Na Demete	ame of	DATE 20c. LO	CATION - CI	ty or Town, Stata , Maryland	
		21. SIGNATURE OF FUNERAL SERVICE LIC	Barr		Muri		ber Funer	al Ho		
within er hours within er hours apletely filled in t cremation, or re-		23. PART I. Enter the disessee, or c ehock, or heert feilure. I IMMEDIATE CAUSE (Finel disesse or condition resulting in death)	let only one ceuse on eed	e Tran	mater the mo	LNJ	ss cardisc or respi	ratory srree	Approximate intervel Between Onset and Doubth	
certificate be execute ording physician and c Hygiene prior to burian other traumatic	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST			-toumest					
E 65 E	MEDICAL C	PART II. Other significent conditions	s contributing to death bu	t not resulting	in the underlying	g ceuse given in P	art I. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
AL law has b Dept.	SICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			S NO C] UNCERTAIN			1 VES 2 NO	
ON OF VII.) DING PHYSICIAN: Th After this certificate death with the State s marked, or iten	BY PHYS	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 ER/Outpet 28e. DATE OF INJURY (Month, Day, Year)	Inpetlant 2 ER/Outpetlant 3 DOA 4 Nursing Home 5 Realdence 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK?			6 Other (Specify) 28d. DESCRIPE HOW INJURY OCCURED ALL TO PERSONNELL			
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	ETED	3 Suicide S Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, etc. (Specify	gh wa	4	4	Courte Z	7.4-11	1+ Airy Dribe	
単 3 2 万 本	COMPL	2 DEDICAL EXAMPLE	CIAN: To the best of my knowled to On the best of examination						cause(a) and manner as stated.	
TO THE HOSPI TO THE FUNEF be filed within	TO BE	296. SIGNATURE AND TITLE OF ERRIFFIEM	men			29c. LICENSE NUMB	25	29d. DATE :	SIGNED (Month, Day, Year)	
		Richard Jones M. 31. DATE FILED (Month, Day, War)		rial Av		stminster	, Marylan	d 2	1157	
	(II	110111 7 TBBS	THE STRUKLES AS	Mall						

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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		1. DECEDENT'S NAME (First		Willow							2. DATE OF		W	95 PAR	3. TIME OF DEATH
		Edwin Pi									11	0,)	95	17:11 м
		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In	yrs. last birth		UNDER 1 YEA	_	IF UNDER 24 HRS.	7. DATE OF			8. BIRTH	HPLACE (State or Foreign
		234-42-9577 1 X M 2 F 68 YRS. MONTHS DAYS HOURS MIN. 4 OF 9 OF 1927 Bay						Bay	ard, WV						
		98. FACILITY NAME GAI	RRETT CO	. MEMORIAL	HOSPI	TAL	9b.	CITY, TOW	VN OR	LOCATION OF D	EATH			NTY OF D	
.	HC H	Rt. 1, Box 8 Thomas Thomas, WV OAKLAND, MD. Tucker							E GARRETT						
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	DIRECTOR	10e. STATE	10b. COUNTY			100		WN OR LO		N					10d. INSIDE CITY LIMITS?
		WV	Tuck	cer			Th	oma	S						1) YES 2 NO
	AL	10e. STREET AND NUMBER							10f. Z	IP CODE			10g. CIT	ZEN OF V	WHAT COUNTRY?
	FUNERAL	Rt. 1, Bo	8 xc							26292				U.	SA
	5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U	.S. ARMED		13. WAS	DECEN	IDENT OF HISPAI	NIC ORIGIN?	Specify Yes	or No.	14. BACE	F — American Indian
		1 Never Married 2 🔀		FORCES? 1 IF YES, GIVE W				If yes	, speci	fy Cuban, Maxica	in, Puerto Ric	en, etc.)			E — American Indian, k, Whita, etc.
	B	3 Widowed 4 Divo	rced			-0			163 2	X NO Specif	у.			Speci	₩: White
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	4	10		•		C	oal	Min	er			Mil	ning		
90	COMPLET	17. FATHER'S NAME (First, M	liddle, Last)						Ti	IS. MOTHER'S NA	ME (First Mid	dle Meiden	Sumame)		
ato		Charles	Edwa	d Mill	er					Clara				ler	
or removal. medical examiner must be notified at once.	B	19a, INFORMANT'S NAME (7				19b. MAI	LING ADD	RESS (Street	of and	Number or Rural					
not	2			ller									2629		
2		ROSE Maile Miller RC. 1, Box o mondas WV 20292													
unst		1 DeBurial 2 Cremetic	n 3 🗆 Remo	oval from Stata	cemete	y, cremator	y or other p	dace)	t O	ror	DATE				
-		1 Separation 2 Cremetion 3 Removal from State Equation 1 Camelagy, cremetory or other place) 1 Donation 5 Other (Specify) 21. Signature Of Funeral, Service Licenses ()										, Mu.			
를		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hinkle Funeral Home, Inc.													
exa		100	to	AKUR	K		1			186, D		WV		260	
removal		23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory except										Approximate			
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the the		disease or condition . A													
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I Hygiene prior to burial, cremation, or other traumatic event, the	_	Company 2 1													
to bu	Ó	Sequentially list conditions, If arry, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
prior trau	Ä	csuse. Enter UNDERLY													1
ne b	윤	CAUSE (Disease or inju that initiated events	יא אַ	DUE TO	(OR AS A CO	ONSEQUENC	CE OF):								
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N iii	CO	one) 2 MEDI	CAL EXAMINE	R: On the basis of as	camination e	nd/or investi	getion, in	my opinior	n, deat	h occured at the	time, dete en	d place, and	d dua to th	e cause(s) and menner as stated.
BTA	ш П	29b. SIGNATURE AND TITLE	от фентине	/1					2	9c. LICENSE NUM	ABER		29d. DATI	E SIGNED	(Month, Day, Year)
be filed within IMPORTANT:	0	/	July	34 / N	0					D3346	5 4				7, 1995
= 0	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH	(ITEM 27)	Type, Print,)	-				747	- v •	. , 1000
		Robert M		ghlin,					۲ 8	. Eal	on - W	V 2	6714	5	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND I	MENTAL HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Miciola, Last) David Hlan	mccre	ary			2. DATE OF DEATH NONTH OVER DE		YEAR 3.	TIME OF DEATH	
P.		175-48-5990	1□ M 2 🖾 F 38	(In yrs. lest birthdey) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 27,	1957	Peni	ACE (State or Foreign	
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it. Pages 1	DIREC	10a. STATE 10b. COUNTY Maryland	Cecil	10c. CIT	y, town or locat Perr	yville			- 1	d. INSIDE CITY LIMITS? VES 2 X NO	
ansit perm	VERAL	100. STREET AND NUMBER 25 Laurel Road			10t.	219	003			T COUNTRY?	
the burial-transit permit. Pages 1,	TO BE COMPLETED BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, OIVE WAR OR DA	2 NO	13. WAS DEC	cify Cuban, Mexica	IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)	8 or No 14	Black, W	American Indian, thita, atc. White	
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be detached at once.		17. FATHER'S NAME (First, Middle, Lest) Ralph L. Mo		riign	t Engine	18. MOTNER'S NA	Airborn ME (First, Middle, Maiden Diane L. 1	Sumame)	ress		
e 5 should notified		19e. INFORMANT'S NAME (Type/Print) Maria McCreary				nd Number or Rural F	Toute Number City or Tow	vn, State, Zip Co	2190)3	
lirector, page r must be		20s. METNOD OF DISPOSITION 1 Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	\ C	PLACEAND DATE OF PLACE AND DAT			1 1	rlestor		State Maryland	
the funeral dival.		22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland									
attending physician and completely filled in by the funeral director, page 5 should be detached for email Hyglene prior to burial, cremation, or removal. Iry, or other traumatic event, the medical examiner must be notified at once.		23. PART I. Enter the diseases, or co ahock, or heart failure. Li IMMEDIATE CAUSE (Finel disease or condition	st only one ceuse on ea	ach line.						Approximata Interval Between Onset and Daeth	
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운동 로	AL C	PART II. Other aignificant conditions	contributing to deeth b	ut not resulting i	n the underlying	ceuse given in	Part J. 24s. WAS AN			RE AUTOPSY FINDINGS A/LABLE PRIOR TO	
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this certification with the riked, or	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM		IRY AT	28d. OEŞCRIBE HOW I	NJURY OCCUP	PED		
R: After or death is mai	ED BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined	28e. PLACE OF INJURY building, atc. (Spec	- At home, term, a	M 1 🗆 Y	ES 20 NO	28t. LOCATION (Street and City or Town, State)		Rurel Route	Number,	
DIRECTO hours aft	6										
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TO THE FUNERA be filed within 7 IMPORTANT: 1	O BE	296. SIGNATURE AND TITLE OF CERTIFIER	MC	-		D 318		29d. DATE S	ONED (MO	onth, Day, Year)	
		30. NAME AND AODRESS OF PERSON WNO	COMPLETED CAUSE OF DEA	ATN (ITEM 27) (Type,	Print)						

ALLIANCE

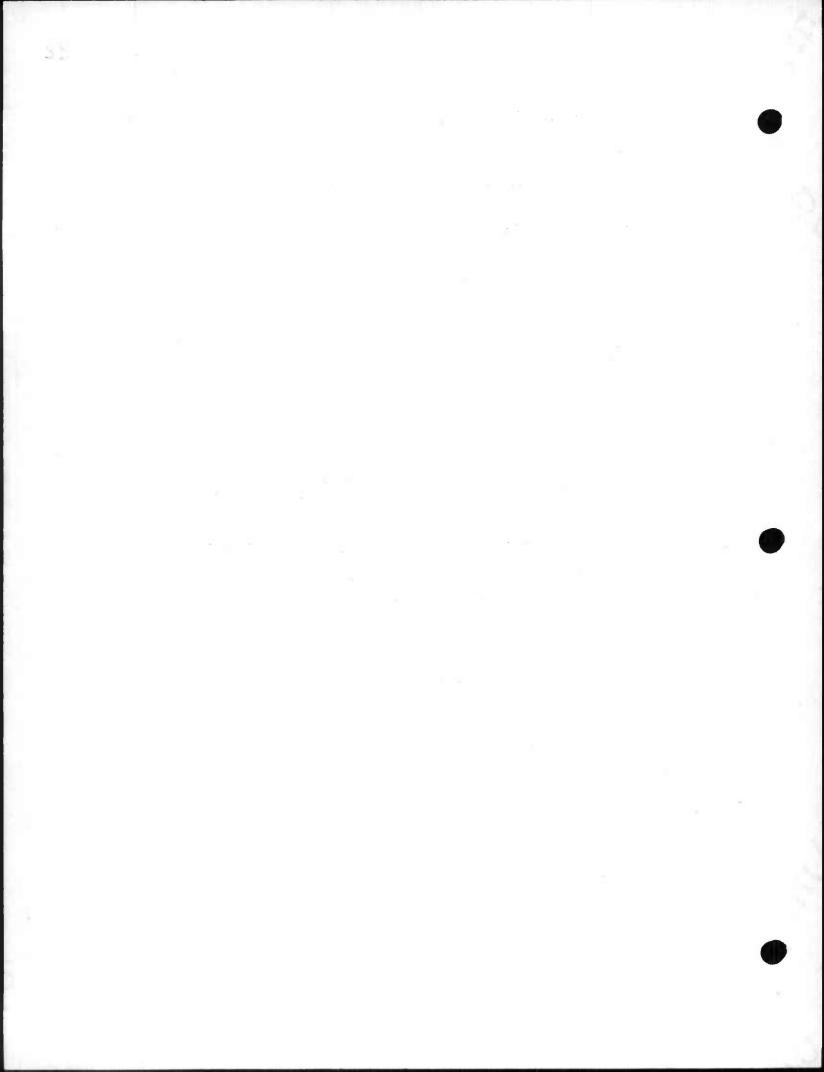
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32 REGISTRAR'S SIGNATURE Dhurlion hardall

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STATE REGISTRAR

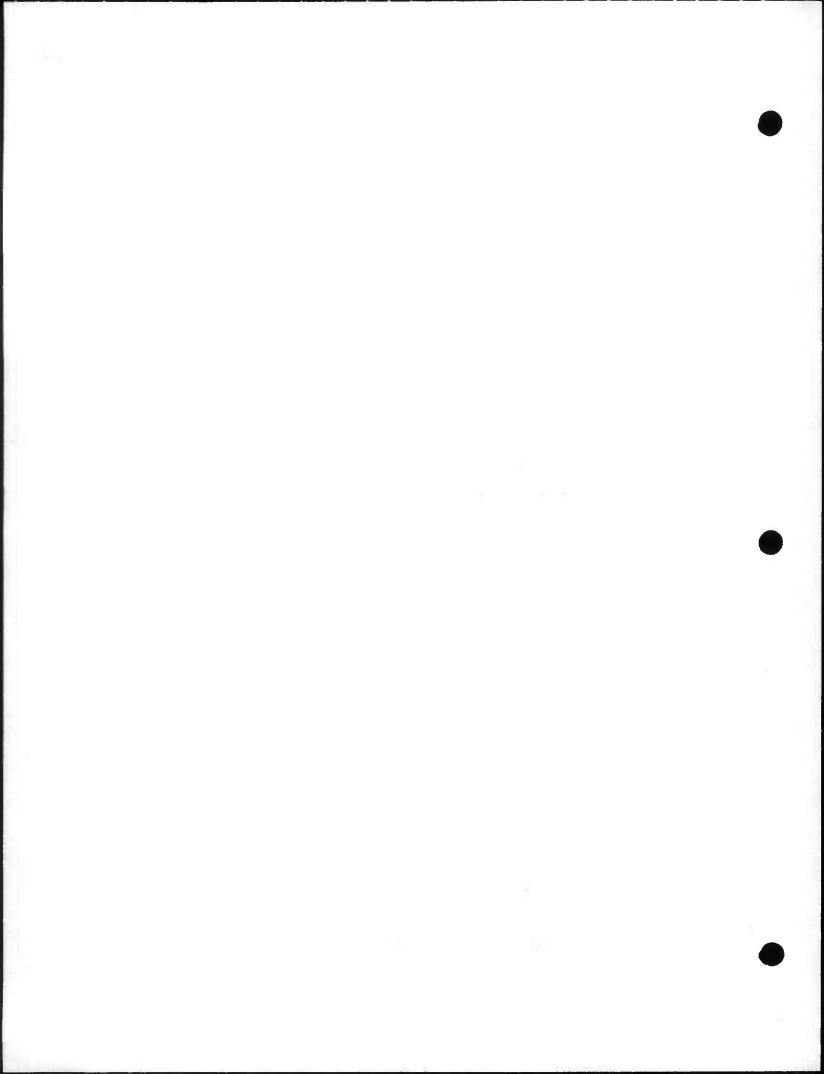
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1995 NOV. 10:15 a ... Moreland Elizabeth 4 SOCIAL SECURITY NUMBER 6. AGE (In yrs. leat birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH BIRTHPLACE (State or Foreign Country) Oct 18 1 🗌 M 2 屎 F DAYS HOURS 216-18-5659 79 YRS 1916 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Anne Arundel Anne Arundel Medical Center Annapolis DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Annapolis 1 YES 2 ND permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2570 Riva Road #9-C funeral director, page 5 should be detached for use as the burial-transit 21401 U.S.A. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 □ YES 2 ☑ ND Specify: 14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2 Married 8 Specify: 3 🔀 Widowed 4 🔲 Divorced White ED 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Public School Teacher Anne Arundel Co. Schools 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 16 Albert W. Trott BE Carrie Hardesty notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Francis Russell Trott 2570 Riva Road #9-C Annapolis, MD 21401 8 20a. METHOD OF DISPOSITION
12 Burtal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Mt. Zion U.M. Church Cem 11-4-95 4 Donation 5 Other (Specify) Lothian, MD 21. SIGNATURE OF TUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Owings, MD hours after death. 20736 completely filled in by the medical 23 PART I. Enter the disea s. or compl ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate allure. List only shock, or heart ona cause on each line. Interval Between 6 IMMEDIATE CAUSE (Final Onset and Death the cremation, disease or condition neumona the death certificate be executed within reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): burial, Cerebrovarular accident CERTIFICATION and Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE DF): the attending physician at Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or Injury DUE TO (DR AS A CONSEDUENCE OF) that initiated events reaulting in death) LAST 10 Injury. PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? has been signed by the Dept., of Health and that shows any 1 TYES TO NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES INO W UNCERTAIN I Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATN (Check only one) E P r this certificate hi Item HOSPITAL:
1 Department 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO PHYSICIAN: 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 26a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, Netural 84 1 YES 2 ND DIRECTOR: After to hours after death v Item 28 is mark 8 Investigation 2 Accident ATTENDING 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 8 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho HOSPITAL (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurad at the time, data and place, and due to the cause(s) and menner as stated. TITLE OF CERFFIE 29b. SIGNATURE AND 29c. LICENSE NUMBER 8 29d. DATE SIGNED (Month, Day, Year) 195 D307 mo 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print) KOBERT KIDGELY 15 32. REGISTRAR'S SIGNATURE Davidson Redall 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68760

pertificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physical	ling physician and completely filled in by the funeral director, page 5 should be detached for use as the burit	ygiene prior to burial, cremation, or removal.	other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicians and approximately selected that the property of th	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buris	be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	OF MARYLAND / DEPA	ARTMENT OF H		NTAL HYGIENE REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DE					3. TIME OF DEATH			
	ALLIE Fair MA 4. SOCIAL SECURITY NUMBER 5. SEX	GGARD	by) IF UNDER 1 YEAR		MONTH DAY YEAR					
	234 90 9743	8. AGE (In yrs. lest birthde)	MONTHS DAYS	HOURS MIN. Jal	tery 15-19	13 Kent	intry)			
_	9a. FACILITY NAME (If not institution, give street and num	e street and number) 9b. CITY, TOWN OR LOCATION O				DEATH				
TOT.	THE JOHNS HOPKINS HOS	NS HOSPITAL BALTIMORE CI				ore				
DIRECTOR	Maryland Calvert	10c. C	ORT REPUBLIC	ION			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
	10e. STREET AND NUMBER						F WHAT COUNTRY?			
FUNERAL	1961 Chestnut Street	20676				United States				
BY FUI	1 Never Married 2 Married FORCE	ECEDENT EVER IN U.S. ARMED IS? 1 YES TOTAL GIVE WAR OR DATES	1 ☐ YES — ★ NO If yes, specify Cuban, Mexican, Puerto Rican, atc				ACE — American Indian, ack, Whita, atc. acch, White			
ED	15. DECEDENT'S EOUCATION (Specify only highest grade completed)		T'S USUAL OCCUPATION of work done during mo		16b. KIND OF BUS	INESS/INDUSTRY	,			
COMPLET		I/4 or 5+)	T use retired.)		an h		ł			
MP	none	housewif	housew.		own h					
ш	17. FATHER'S NAME (First, Middle, Last) Frank Adams			16. MOTHER'S NAME. Hactie	Jane Bullio	Sumame) N				
TO B	196. INFORMANT'S NAME (Type/Print) B.B. Maggard	304 D	ING ACCRESS (Street I	Prince Freder	Prick, Maryl	and 20678				
	20e. METHOD OF DISPOSITION 1 SyBuriel 2 □ Cremation 3 □ Removal from S 4 □ Donation 6 □ Other (Specify)	20b. PLACE AND DA	TEOF DISPOSITION (No	wenter 2, 19	995 Et. To	cation — City or	Town, State			
	21. SIGNATURE OF FUNEBAL SERVICE LICENSEE	Waters Fine	22. NAME A	ID AOORESS OF FACILI	TY	1 170-				
	+ 7(20 UD	1	4405 B	comes Is. Ro	Rauson Fu Port Reo	neral Hui ublic Mar	e vland 20676			
550	23. PART i. Enter the diseases, or complication						Approximats			
	iMMEDIATE CAUSE (Finsl disease or condition resulting in death)	disease or condition non a condition interchan 74 hours								
		DUE TO (OR AS A CONSEQUENCE	E OF):	(h/ = ==1	10.4		24 hours			
RTIFICATION	Sequentially list conditions, If any, leading to immediate									
FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A CONSEQUENCE	E OF):							
ERT	resulting in death) LAST									
AL CEI	PART II. Other significant conditions contribu						24b. WERE AUTOPSY FINDINGS			
OICA	chronic obstra	ctive pulm	smary a	disease	PERFOR		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDIC		<u> </u>			_		1 - YES 2 NO			
ä	DID TOBACCO USE CONTRIBUTE 1		YES NO DEATH (Check only one)	UNCERTAIN						
SIC!	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 I Input	TAL:	OTHER:		7.04					
PHYSICIAN:	27. MANNER OF DEATH 28s.	1 Marsiant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED								
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	M 1	PRK? YES 2 NO						
ED	2 Solicide 3 Suicide 4 Could not be detarmined 28a. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 28b. PLACE OF INJURY — At home, larm, street, factory, office City or Town, State)									
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the book only one) 2 MEDICAL EXAMINER: On the book one of the book						se(s) and manner as stated.			
	29b. SGNATURE AND TITLE OF CENTIFIER	29b. GGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (#								
TO BE	Dreyny Violey	- MD		M609	5	Defo!	per 30, 1995			
	30. NAME AND ADDRESS OF PERSON WHO COMPLET	TED CAUSE OF DEATH (ITEM 27) (I	Type, Print) Hopkins	lospital 7	ower (10	Be Itim	are MD			
	31. OATE FILED (Month, Day, 1987) 32. H	EGISTRAR'S SIGNATURE		*						
Ш	NOV - 2 1995 A	in athurbus hardal	4				DHMH.16 Ray 1/89			

U V Section 1996 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

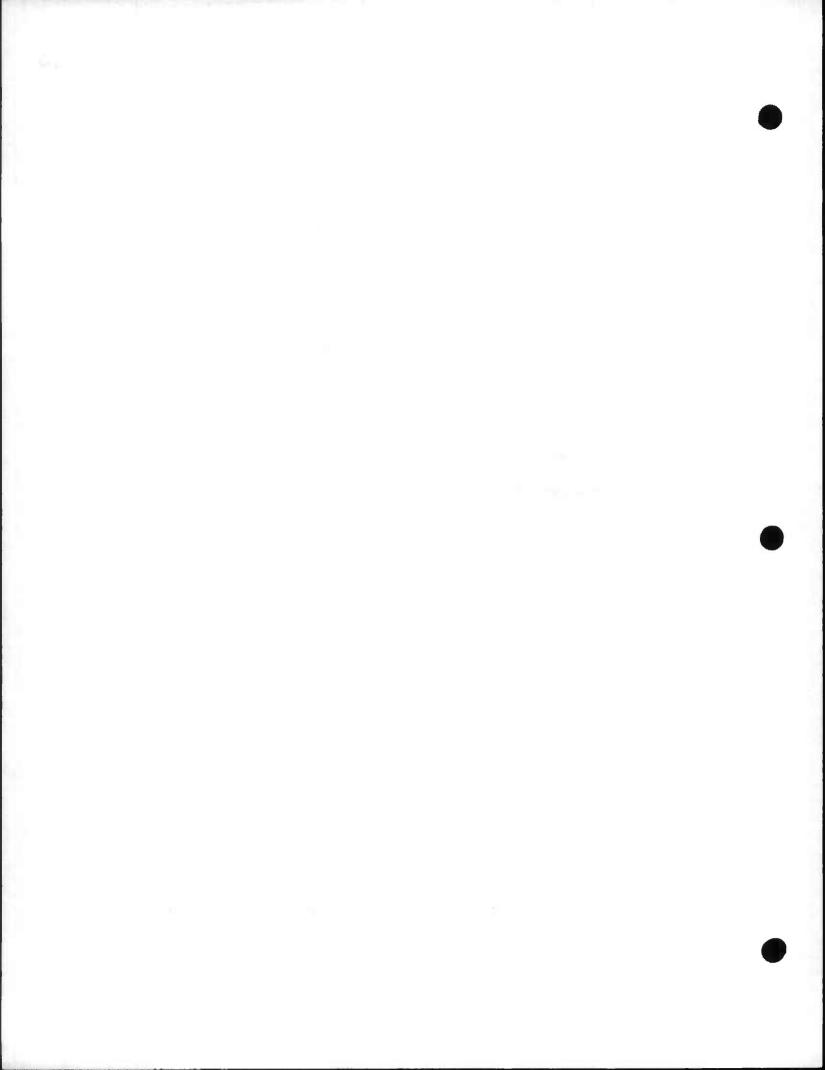
		1 DECEDENT'S NAME (CI-	Adiabatha danah												
		1. DECEDENT'S NAME (First) James L		Miller							2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		5. SEX	8 AGE (In	yrs. lest b	detholms) IE 68	DER 1 YE		DER 24 HRS.	NOVEI		3]	995	4:55 Pm
-		174-24-253		1 XM 2 - F		57	YRS. MONT				July	23, 1	928		PLACE (State or Foreign nsylvaina
pinous	_	9e. FACILITY NAME (If not in						YOT ,YTE	VN OR LOC	ATION OF D	EATH		9c. COUN	NTY OF DI	EATH
2, 3	стоя	Southern M	aryla	nd Hosp	<u>ital</u>	L Ce	nter		Clir	nton			Prin	ce i	Georges
Pages 1,	REC	10a. STATE	10b. COUNT	r			10c. CITY, TOV	N OR LO	CATION						10d. INSIDE CITY
.F.	🗖	Maryland		ice Georg	e's		Fore	stvi	lle						LIMITS?
sit permit.	RAL	10a. STREET AND NUMBER 5911 Addiso							10f. ZIP C	2074	7				tates
020 physician. bunial-transit	FUNE	11. MARITAL STATUS	11 11/0	12. WAS DECEDEN	T EVER IN	U.S. ARME	n I	13 WAS	DECENDEN		NIC ORIGIN? (Encelly Voc			- American Indian,
215-0020 attending physician. se as the bunal-trar	BY FI	1 Never Married 2 3 Widowed XX Divo		FORCES? 1	MAR OR DAT	2 NO		If yee	, specify Co	ben, Mexico	an, Puerto Rica	en, atc.)	S. 1.0-	Black	, White, etc.
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the hos detach	S I	17. FATHER'S NAME (First, M									AME (First, Mide		Sumame)		
E E DA	BE	Robert E.		ler							e Burt				
be retained by the ge 5 should be det	2	Elva C. Sco		az							Route Number, ive, C				024
6 may stor, pa		20a. METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State			DDATEOFDIS			5 199	OATE		CATION —		vn, State yland
Page al direc		21. SIGNATURE OF FUNERA		ENSEE	_ 1160	· CLC									, INC 6633
death death death death death		Malil.	Ba	tr- Cono	lan		- 1	old	Alexa	andri	a Ferr	y Roa	ad, C	lint	on, Md
hours after ed in by the or removal		23. PART I. Enter the di abook, or he	seases, or c	complications the	t caused i	the deeth	h. Do not er	tar the	moda of	dylng, suc	h as cerdiad	c or respli	ratory arm	est,	Approximate Interval Between
filled fon, or		IMMEDIATE CAUSE (Fin					0 0	10	^ \ \		4 10	/		0	Onset and Death
vithin pletely remati		disease or condition													
executed within and completely o burial, cremar matic event,	z			BR	270	117	2 PN	EII	WW.	NIA)				
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Educate to physici per prior tra	-ICA	cause. Enter UNDERLYI CAUSE (Disease or Inju		C. DUE TO	(OR AS A C	CONCEOUR	ENCE OD:								
death certificate be attending physician ental Hygiene prior iny, or other trau	CERTIFICATION	that initiated events reaulting in deeth) LAS	т .	d	(UN AS A C	CONSCOU	ENGE OF):								
		PART II. Other algolfica	nt condition	a contribution to	al a ath had	A							7		1
2 2 4 7	MEDICAL	DEHN	DRA	T TAN	deeth but	t not resi	uiting in the	underi	ying caus	e givan in	Part I. 24	PERFORI		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
puires the signed Health a	EDI	DNE	SWAT	NIA							1	YES 2	NO	-1	OF DEATN?
w required been of the state of	_	DID TOBACCO U	-		USE OF	DEATH	YES T	1 NO	□ UN	ICFRTAII	МП				1 TES 2 NO
has has	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?					OF DEATH (Ch	ick only o							
SICIAN: The certificate in the State in the State in the State in the State in the state in the	YSIC	1 YES 2 NO		HOSPITAL:	ER/Outpat	tlent 3 🗆	DOA 4 □		forme 5 🗆	Residence	8 Other (S	ipecify)			
The this			Pending investigation	28a. DATE OF (Month, D		2	18b. TIME OF INJURY		INJURY AT WORK?	□ NO	28d, OEŞCRI	IBE HOW IN	JURY OCC	URED	
OR ATTENDING DIRECTOR: After hours after death item 28 is mail	ED BY	3 Sulcide 8	Could not be	28e. PLACE O building,	of INJURY -	At home,	, farm, street,	fectory, c	rffice		28f. LOCATIO	ON (Street a fown, State)	nd Number	or Rural Re	oute Number,
OR AT DIRECT HOURS	LET	29a. CERTIFIER	TEVINO BUNG		55U- V.	1000000									
로 로 전 보	COMPL			CIAN: To the best of R: On the besis of a											end manner as stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	lli.	296. SIGNATURE AND THUE						1	_	ICENSE NUI					(Month, Day, Year)
TO THE HOSPIT TO THE FUNER De filed within	TO BE	Kld	120	mo	X	(MOG	200	T.)2'	774	4	>	11-6	1-95
	-	RAJ CO	MT A	COMPLETED CAU	SE SE DEAT	THUITEM 2	31 D	15	Ct	FA	enA	1,2	D	C	MOINI
		31. DATE FILEO (Month, Day, NOV)	7 199	32. REGISTRÁ	A Sural	TURE LON-RO	rdall			-					

DIVISION OF VITAL RECORDS, P.O. BOX 68760

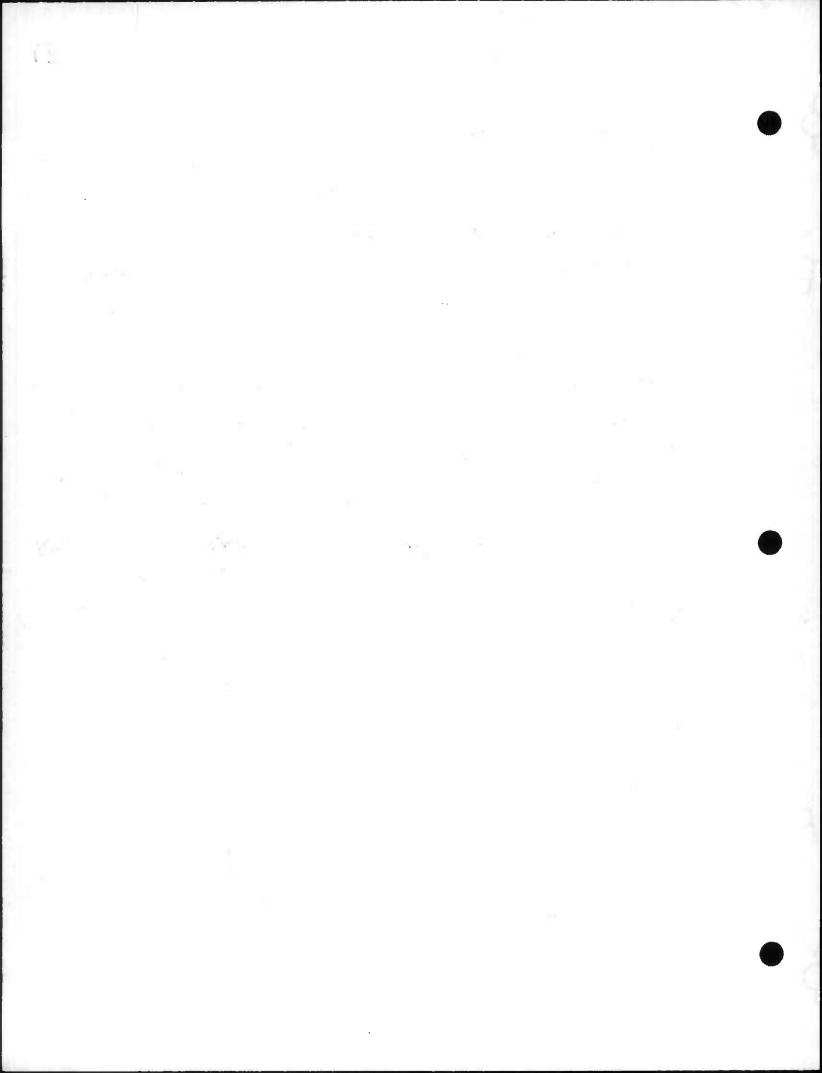
FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Lest)									2 DATE	OF DEATH	_		
			chard	х.	M	cLe]	17 25				MONT	2,199	F	YEAR	3. TIME OF DEATH 11:20 PM
	4. SOCIAL SECURITY NUME		5. SEX	_	in yrs. last				1				5		
	216-03-7345	En	1 X M 2 F	200000000000000000000000000000000000000	in yrs. iest i 39		IF UNDER	DAYS	IF UNDER	MIN.	7. DATE (Mont)	OF BIRTH	1000	8. BIRTH Countr	IPLACE (State or Foreign ry)
			-		,,,	YRS.						il 30,	1906	Mary	yland
	90. FACILITY NAME (If not in									ON OF DE	ATH			NTY OF D	
0	and the latest the second of t		ile				Up	per	Marl	boro			Pr:	ince	George's
5	RESIDENCE OF DEC	10b. COUNTY													
2							Y, TOWN								10d. INSIDE CITY
0	Maryland	Prin	<u>ce George</u>	e's		Up	per l	Marl	boro						1 YES 2 NO
M	14815 Che	cos T	200					10	t. ZIP COD	_					VHAT COUNTRY?
FUNERAL DIRECTOR	14010 (16)	.sea L							207	72			Uni	ted s	States
5	11. MARITAL STATUS	1100-0-1	12. WAS DECEDEN FORCES? 1	T EVER IN	U.S. ARM	ED	13.	WAS DEC	ENDENT (OF HISPAN	IIC ORIGIN	i? (Specify Yes Rican, atc.)	or No-	14. RACE	- American Indian,
ВУ	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR DA	TES	•			2 X X 10			Mican, atc.)		Speci	k, White, etc.
	X wooded 4 Divo	Cou	<u> </u>											Wh:	ite
Ĕ		EDENT'S EDU		- 1	16e. DECI	EDENT'S	USUAL O	CCUPATI	ON ost of working	na	16b	KIND OF BUS	INESS/INC	USTRY	
iy	Elementary/Secondary (0	-12)	College (1-4 or 5	+)	life, L	Oo NOT us	e retired.)								
P	12		5T		Rea	al E	stat	e Br	oker	•		Contra	ctor		
COMPLETED	17. FATHER'S NAME (First, M.	iddle, Last)							18. MOT	HER'S NAM	ME (First, i	Middle, Meiden	Sumeme)		
ш	Adam Farle	McLe	llan 💮						Ma	ry C	ecil	ia Bra	dy		
TO B	19a. INFORMANT'S NAME (7)	rpe/Print)	252		19b.	MAILING	ADDRES	S (Street	and Number	or Rural A	loute Num	ber, City or Town	n. State, Zip	Code)	
7	Francis X.	McLel	lan		P.	.0.	BOX	#76.	aaU	er M	arlb	oro, M	d 20	772	
	20e. METHOD OF DISPOSITI			20b.											wn. Stata
Ì	Buriel 2 Cremation 4 Donation 5 Other		oval from State	Ceme Re	etery, crem	atory or or	her place)	Ceme	terv	, 0,1	١	E 20c. LO	ton.	Marv	land
	21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE	1 10	JULLI		22.	NAME A	ND ADDRE	SS OF FAC	CILITY -	- a There	- 20 7	IIcm	o Tna 6622
- 1	D 1895	/.) _				101	4 A1	evan	dria	Fer	rv Roa	d. C	lint	e,Inc 6633 on,Md 20735
_	110 34	467													011/124 20700
	23. PAPIT I Enter the di shock, or he	seeses, or c	complications the List only one cau	it caused ise on ea	the deep	th. Do r	ot enter	the mo	de of dy	ing, such	as care	diec or reepi	ratory arr	rest,	Approximate Interval Between
ı	IMMEDIATE CAUSE (Fin			,											Onset and Death
	disease or condition resulting in death)	→	e. DUE TO	wt.	te		- 9	0	01						2712
1	re-entrace and		DUE TO	(OR AS A	CONSECU	ENCE OF	F):								
Z	Sequentielly list conditi		b												
CERTIFICATION	If any, leading to immed	late	DUE TO	(OR AS A	CONSEQU	ENCE OF	ን:								
2	CAUSE (Disease or Inju		c												
	that initiated events resulting in death) LAS		DUE TO	(OR AS A	CONSEQU	ENCE OF	7):								
H H	resulting in death) LAS		d												
	PART II. Other significe	nt condition	e contributing to	death bu	it not rea	nultina l	n the ur	derlyln	C CRUSA	alven le f	Dart I	24a. WAS AN	ALFTTORON	100	MEDE MITTORY CHICAGO
EDICAL						outing i		deriyii	g cause (given in r	rail i.	PERFOR		240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
											-	1 TYES 2	NO.		OF DEATH?
Σ											_				1 TES 2 NO
ž	DID TOBACCO U		RIBUTE TO CA						UNC	ERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	2	26. PLACE	OF DEAT	H (Check								
YSI	1 YES 2 NO		1 Inpetient 2	ER/Outpe	itlent 3	DOA			6 5 AR	sidence (6 🗆 Othe	r (Specify)			
표	27. MANNER OF DEATH	2000	28e. DATE OF (Month, D			28b. TIM	E OF URY	28c. INJ WO	URY AT		26d. DES	CRIBE HOW IN	JURY OCC	CURED	
BY		Pending nvestigation					М		YES 2] NO					
		Could not be	28e. PLACE O building.	F INJURY etc. (Speci	— At home	e, farm, s	treet, fact	ory, offic	•			ATION (Street e	nd Number	or Rural R	loute Number,
2	4 Homicide	latermined		()	.,,						Only	or lown, State)			
COMPLETED	29a, CERTIFIER	FYING PHYSI	CIAN: To the best of	my knowle	edge, dest	h occum	d at the t	Ime dete	and place	and due t	to the cou	en(a) and man		077	
ž I) end menner as stated.
8	296. SIGNATURE AND TITLE											eria piace, eri			
H	STATE AND TITLE	1	1							ENSE NUMI			29d. DATE	E SIGNED	(Month, Day, Year)
2	(my	10							D3	4405	>			113	(4)
	30. NAME AND ADDRESS OF							6	Dor	1/1-	- T-	200	71 5 7	200	
	Andrew Dobi		3231 Su			ane	# A-	0, .	BOM16	e, Ma	т.Лт	una 20.	/TD_7	206	
	31. DATE FILED (Month, Day, 1		32. REGISTRA												
	NOV 0	7 1995	Julia	Thurtle	ex-ha	dall									



	REGISTRAR		CERTIF	ICATE O		MENTAL HYGIEI REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)		-			2. DATE OF DEATH	DAY	3. TIME OF DEATH			
	Domin		MORI			NOUGMBEI					
	4. SOCIAL SECURITY NUMBER 579–46–9399		yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	6	B. BIRTHPLACE (State or Foreign Country)			
		33	YRS.		11000	March 3,1		Washington I			
H C	SOUTHERN W	4	PITAC	9b. CITY, TOWN	OR LOCATION OF DI	EATH	9c. COUNT	YOF DEATH			
ECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			TY, TOWN OR LOC	ATION		PIG				
DIR		e George's		Clinton	ATION			10d. INSIDE CITY LIMITS? 1 YES 2 1 10			
FUNERAL	10e. STREET AND NUMBER	<u> </u>			IOF. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?			
NEF	6209 Edward Drive				20735		11	II.S.A.			
F	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN L FORCES? 1 XYES	J.S. ARMED 2 NO	13. WAS DE	ECENDENT OF HISPAI	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	e or No— 1	4. RACE — American Indian, Black, White, etc.			
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE 1954-195	ES		S 2 NO Specifi		- 1	Specify:			
ED	15. DECEDENT'S EDUC	ATION 1		USUAL OCCUPAT	CION	16b, KIND OF BU		Caucasian			
ETE	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of life, Do NOT u	work done during n	nost of working	Teb. KIND OF BO	STRY				
COMPL	12th	N/A	Superi	ntenden	t	Glass Company					
	17. FATHER'S NAME (First, Middle, Last) Anthony Morisi					ME (First, Middle, Maide	,	•			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	Virginia Cecilia Enrico MAILING ADDRESS (Street end Number or Flural Floute Number, City or Town, Stete, Zip Code)							
은	Janet R. Morisi										
	209 METHOD OF DISPOSITION	20b. P	LACE AND DATE	OF DISPOSITION /	Name of Novem	linton Mai	CATION - CII	20735 ly or Town, State			
- 17	1 X Furial 2 Cremation 3 Remo			on Como	harr 10	05 07					
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22. NAME	AND ADDRESS OF FA	CILITY	inton,	Maryland Home, Inc.			
Ý	+ Charles X	Belans	el)	6633	Old Mlev	ndria For	ierar i	Clinton, Mo			
	shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
핑											
NA N	PART II. Other algnificant conditions	contributing to death but	not reaulting	in the underlying	ng cause givan in	Part I. 24a. WAS AI PERFO		24b. WERE AUTOPSY FIND AVAILABLE PRIOR TO			
MEDIC						1 🗆 YES	2 🐧 NO	OF DEATH?			
	DID TODA CCO LICE CONTR	IDUITE TO CALLES		- M r				1 TYES 2 NO			
AN	DID TOBACCO USE CONTR			TH (Check only one	UNCERTAIN	1 [
SICIAN:	EXAMINER?	HOSPITAL:		OTHER:							
PHYS	27. MANNER OF DEATH	28a. DATE OF INJURY	ant 3 L DOA		me 5 Residence	6 Other (Specify) 28d, DESCRIBE HOW	IN HIEW COOK				
	1 Natural 5 Pending	(Month, Day, Year)		JURY W	YES 2 NO	280. DESCHIBE HOW	INJUHY OCCUI	MED			
B	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY —	Al home, farm,			28f. LOCATION (Street	and Number or	Rural Route Number			
	4 Homicide detarmined	building, atc. (Specify))			City or Town, State					
	29e. CERTIFIER	to the cause(a) and ma									
		. On the heals of exemination a		or, in my opinion,	gestu occured at the	lime, date and place, a	nd due to the o	cause(a) end manner as stat			
COMPLETED	one) 2 MEDICAL EXAMINER	: On the basis of examination a									
BE COMPLETED		: On the basis of examination a	•		29c. LICENSE NUN	IBER GW1	29d. OATE S	SIGNED (Morth, Day, Year)			
COMPLETED	one) 2 MEDICAL EXAMINER 216. SIGNATURE AND TITLE OF CERTIFIER					1941)	29d. OATE S	SIGNED (Modin, Day, Year)			
BE COMPLETED	one) 2 MEDICAL EXAMINER		H (ITEM 22) (7/2)	p, Print)		1#601	29d. OATE S DONN	SIGNED (Maglin, Day, Your)			

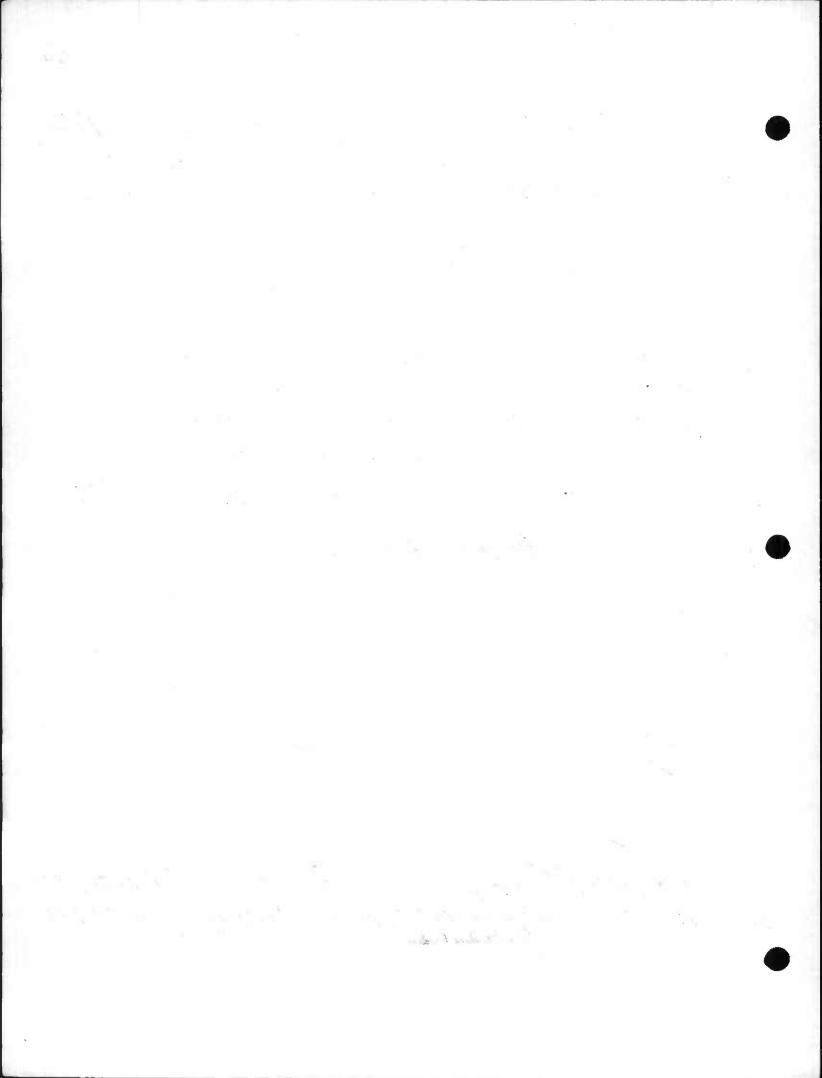


TO THE HOSPITAL OR ATTENDIN'S PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 6876(

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

						95	3	4828
FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HE		IENTAL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Last)	ERIC SEAN M	OSLEY MO	3/ey		2. DATE OF DEATH	25,19	EAR 3. T	IME OF DEATH
4. SOCIAL SECURITY NUMBER 579-86-4311 9a. FACILITY NAME (If not institution, give s	1 □ ₩ 2 □ F	24 YRS. M		HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) FEBRUARY 1	1.71	Nasi	E (State or Foreign
4180 SUITLAND ROA			SUITLAN		ин .	PRIN(ORGE's
	TE GEORGE's		TLAND				XX	INSIDE CITY LIMITS? YES 2 NO
100. STREET AND NUMBER 4180 SUITLAND ROA	AD SUITE 340	401		743			N OF WHAT	COUNTRY?
11. MARITAL STATUS 12. MARITAL STATUS 12. Married 2	12. WAS DECEDENT EVER IN FORCES? 1 YES	N U.S. ARMED	13. WAS DECE	IDENT OF HISPANI Ify Cuban, Maxican	C ORIGIN? (Specify Yea , Puerto Rican, atc.)		. RACE — A Black, Whi Specify:	merican Indian, Ita, atc.
15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S US	rk done during most	of working	16b. KIND OF BUS	INESS/INDUS		
Elementary/Secondary (0-12) 10th	College (1-4 or 5+)	ilie. Do NOT use i			PRIV			
17. FATHER'S NAME (First, Middle, Last) GREGORY CRAWFORD 190. INFORMANT'S NAME (Type/Print)				ROXANI	NE HAYES			
	(MOTHER)				ITE #401;			vm 20743
20a. METHOD OF DISPOSITION	1 000	PLACE AND DATE OF	DISPOSITION (Nem			CATION — Cit		
4 Donation 5 Other (Specify)			MEMORIA	L PARK	11/1/95 I	ANDOVI	ER, M	ARYLAND
▶ GKENDA M	Gundu)				NKINS FUNE	RAL HO	OME,	INC.
23. PART I. Enter the diseases, or shock, or hast failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Hodg king		· · · · · · · · · · · · · · · · · · ·	or dying, soci	as caldisc of festi	ratory sites		Approximate Interval Between Onsat and Death
Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	с.	A CONSEQUENCE OF):						
	d						1	
PART II. Other aignificant condition	ns contributing to death b	out not resulting in	the underlying	cause given in i	Part I. 24a. WAS AN PERFOR	RMED?	CDN	LABLE PRIOR TO IPLETION DF CAUSE DEATH?
DID TOBACCO USE CONT	PIRLITE TO CALISE C	DE DEATH YES	ПОП	UNCERTAIN		10	1 🗆	YES 2 NO
25. WAS CASE BEFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only one)	OTTOLKIAII				
1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out	petlant 3 DOA 4		5 Prisaldanca	3 Other (Specify)			
27. MANNED OF DEATH 1 Netural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY WOR	RY AT K? S 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCU	RED	
2 Accident Investigation 3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm, str	reet, factory, offica		281. LOCATION (Street and City or Town, State)	and Number or	Rural Route	Number,
one)	SICIAN: To the best of my know							menner as stated.
296. SIGNATURE AND TITLE OF CERTIFIE	Courses	(M)		PAIZ S	30	BUR	Les of	1th, Day, Year)
Much P.Ro	HO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, F	Royh	um Ct.	Cp Spris	us . 71	282	0748
31. DATE FUCTOR 31 1995	PEGIS PAR'S SIGN	Charles			•	0		



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RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR MARY LOUISE MASSEY 10-24 -95 1:22 A SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 - M 2 - F YRS. 205-38-8455 47 12-25-47 N.C permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1405 4th Street Glenarden Prince Georges 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Prince Georges 1 YES 2 NO Glenarden FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? as the burial-transit 1405 4th Street 20706 USA attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married & Married 1 TES RENO Specify: BY 3 Widowed 4 Divorced Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY use Q Elementary/Secondary (0-12) College (1-4 or 5 +) Program Analyst Government detached 12 once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumarne) Ħ funeral director, page 5 should be Redmond Johnson Fannie L. Morgan BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Rogers L. 1405 Massev 4th Street, Glenarden, MD 20706 pe 20s. METHOD OF DISPOSITION

1 September 2 Cremation 3 Removal for 4 Donation 5 Other (Specify)

21. BIGHATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Must Harmony Mem. Park 10-28 Landover, MD examiner 22. NAME AND ADDRESS OF FACILITY Strickland Funeral Svc 9507 Silver Fox Turn, Clinton, MD 2073! signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. hours after medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final the disease or condition 8 MOS Metastatic cancer, primary unknown resulting in death) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. OR ATTENDING PHYSICIAN: The law requires that the v DIRECTOR: After this certificate has been signed by the hours after death with the State Dept. of Health and Me 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO has be Dept. 1 PHYSICIAN: DIVISION OF VITAL 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 ☐ YES 2 🔀 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA me St Residence 6 - Other (Specify) 0 27. MANNER OF DEATN 26s. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE NOW INJURY OCCURED 28b. TIME OF 28c, INJURY AT WORK? marked, 1 🔀 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 6 Could not be determined COMPLETED 28 4 Homicide If Item 29s. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL (HOSPITAL THE HOSPITA
TO THE FUNERA
De filed within 77
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 296_SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Kockelle S Hardieku D37391 (Maryland) 10-25-95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Rochelle Hardy 12164 Central Ave. Suite 206, Mitchelville, MD 32 REGISTRAR'S SIGNATURS

Land of the second

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without beath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC	MENT OF I	EALTH AND	MENTAL HYGIE		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY Y	3. TIME OF DEATH
JOHN	W. MILLE	R			OCTOBER		95 5:27PM M
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
577-50-1011 9a. FACILITY NAME (If not institution, give street	ot and number)	8 YRS.	ONTHS DAYS	OR LOCATION OF D	MAY 26,	1937 5	SCOTTLAND, NO
PRINCE GEORGE'S	HOSPITAL			ERLY			ICE GEORGE'S
10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
MARYLAND PRIN	CE GEORGE	'S HYA	ATTSVI	LLE		10a CITIZEI	1 XXES 2 □ NO
5360 QUINCY PL	ACE #101		10	20784		1,000	JSA
I .	12. WAS DECEDENT EVER I	N U.S. ARMED			NIC ORIGIN? (Specify	Yea or No 14	I. RACE — American Indian, Black, While, atc.
Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 1 YES IF YES, GIVE WAR OR D 6/7/54-5/	ATES NAVY		S 2 X NO Specif	in, Puarto Rican, atc.) y:		Specify: BLACK
15. DECEDENT'S EDUCA (Specify only highest grade co		18a. DECEDENT'S US (Give kind of work	rk done during m		16b. KIND OF I	IUSINESS/INDUS	TRY
Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	HEAVY E		ENT OPE	ERATOR	GOVER	RNMENT
17. FATHER'S NAME (First, Middle, Last)			_	18. MOTHER'S NA	ME (First, Middle, Maid	en Surname)	
JOHN MILLER				CONN	WIE MILL	ER	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street	and Number or Rural	Route Number, City or	own, State, Zip Co	ode)
LESLEY WARD/ DA					ATTSVIL		
20a. METHOD OF DISPOSITION N Burlat 2 Cremation 3 Ramov 4 Donation 5 Other (Specify)	al from Stata cer H	PLACE AND DATE OF netary, cramatory or othe ARMONY N	r place) LEMORI	eme of AL PARE			OOVER, MD
21. SIGNATURE OF FUNERAL SERVICE LICEI	A BU	Who		.B. JEN LANDOV		NERAL LANDO	HOME OVER, MD20785
23. PART I. Enter the diseasea, or co-	mpliceliona that ceuse	d the deeth. Do no	t enter the m	ode of dying, aud	ch as cardiec or re	piratory arrea	
shock, Dr haart failura. Li iMMEDIATE CAUSE (Final disease or condition resulting in dasth) a.	PULMO	WARY					Interval Between Onset and Death
	CONGES	A CONSEQUENCE OF):	PORT	FOILVI	et \	10	
Sequentially list conditions if any, leading to immediat	DUE TO (OR AS	A CONSEQUENCE OF):	0,4 -7	1 1100	11		
cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (00 40						
that initiated aventa resulting in death) LAST	DOE TO (OH AS /	A CONSEQUENCE OF):					
- C c							
PART II. Other significant ephditions	contributing to death I	out not resulting in	the underlying	ng cause given in	PERI	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRI	DUTE TO CAUSE O	NE DEATH VEC	T NO X	Z UNICEDTAL			1 TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE C	26. PLACE OF DEATH			ПП		
	HOSPITAL:		OTHER:	me 5 🗆 Basidenca	8 Other (Specify)		
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Yeer)	28b. TIME	DF 28c. IN	JURY AT ORK?	28d. DESCRIBE HO	W INJURY OCCU	RED
1 Netural 5 Pending 2 Accident Investigation	(inchin, buy, 100)			YES 2 NO			
3 Suictde 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, atr ocify)	reel, factory, offi	ca	281. LOCATION (Stre City or Town, St		Rural Route Number,
CONSCR ONLY	AN: To the beat of my know						i. cause(a) and manner as stated.
29b. SIGNATURE AND THE OF CERTIFIER	2/11	-	Nac	29c. LICENSE NU	MBER -092	29d. DATE S	SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO		EATH (ITEM 27) /Tope (DING-			2/2	720/33
MARK PARK)	JURSTMD	7305 L	BACT.	IVE COL	LEGE PA	K MI	20740
OCT 31 1995	Jalia Davida	erhabit					

	FOR STATE REGISTRAR
100	1. DECEOENT'S NAI
1	
	4. SOCIAL SECURIT
l	084-34-
ŀ	9a. FACILITY NAME
	Southern
Ì	RESIDENCE O
l	10a. STATE
l	New Yorl
ľ	10e. STREET AND N
l	140-24
ſ	11. MARITAL STATUS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

- 1											TEG. NO.			
	1. DECEOENT'S NAME (First		IAN	me	7ck1	- U				2. DATE OF	DEATH	WY .	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER							·		UCIO	SER	50.	95	12.24 M
	084-34-325		5. SEX	8. AGE (In yrs.	lest birthday) 54 YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE OF (Month, De	ev. Year)	061	Country	PLACE (State or Foreign
	9a. FACILITY NAME (If not in	natitudian ahm at	met and sumbari			21 212					13			da Cnty, SC
œ				1		9b. CIT			ON OF DE				NTY OF DE	
DIRECTOR	Southern Ma		Hospita	11			CT:	into	a, MI)		Prin	ice G	eorges
	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
뜻	New York	One	ens						- V-	.1.				LIMITS?
	10e. STREET AND NUMBER		CHS			Jame	_		Yor	- K				1 YES 2 X NO
FUNERAL	140-24 161						101	. ZtP COD						HAT COUNTRY?
빌		Stree							434				ted	States
3	11. MARITAL STATUS 1 Never Married 2	Manufact	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. YES 2		13.	WAS DEC	ENDENT (OF HISPAN	IC ORIGIN? (S	pecify Yea	or No-	14. RACE Black	- American Indian, White, atc.
BY	3 Widowed 4 Divo		IF YES, GIVE W						Specify		11, 0102)		Specif	V.
														Black
OE	15. DEC (Specify onl	EDENT'S EDUC y highest grade	completed)		DECEDENT'S (Give kind of	work done	during mo	ON st of worki	ng	16b. KIN	ID OF BUS	INESS/IND	DUSTRY	
۳	Elementary/Secondary (0	3-12)	College (1-4 or 5 a	-)	life. Do NOT u	,								
COMPLET			1		Tele	phor	ie C.						phone	e Company
8	17. FATHER'S NAME (First, M									ME (First, Midd	le, Maiden	Sumame)		
띪	Hampton W							Jι	ılia	Allen				
2	190. INFORMANT'S NAME (19b. MAILING	ADORES	S (Street a	nd Numbe	r or Rural R	loute Number, (City or Town	, State, Zip	Code)	
-	Alonzo Mac	key			140-2	24 16	51 St	reet	Jam	aica 1	N.Y.	1143	4	
	20a. METHOD OF DISPOSIT		wel from State		E AND DATE					DATE	20c. LO	CATION -	Clfy or Tov	rn, Stata
	4 Donation & Other		- Tom State	Cernetery	uantic	ther place)	tion	na1		11/3		Tria	ngle	. VA
	21. SIGNATURE OF FUNGRA	L SERVICE TIC	ENSEE	1		22.	NAME AN	D ADDRE	SS OF FAC	PILITY				
	► / / //en		Mano	11						Pope 1				
\dashv	22 DEPAY Before the el	()	rogin	- 41 3			538	Marl	lboro	Pike	Fore	stvi	lle,	MD 20747
	23. PARTM. Enter the dehock, or h	eart feilure. L	ist only one ceu	se on each il	deeth. Do i ine.	not enter	r the mo	de of dy	ing, such	n es cardíac	or respi	ratory arr	rest,	Approximete Intervei Between
	IMMEDIATE CAUSE (Fir													Onset and Death
	disease or condition resulting in death)	+ .	SEN.	ere	an	OXI	·C	en	cet	halo	o Pa	uth	4	40 m
z	Sequentially liet conditi	ions 6	Suc	dden	C	110	tre	10	Q)	reg	7			
ĔI	if any, laading to imme	diate	DUE TO	(OR AS A CONS	SEQUENCE O	F):								
CERTIFICATION	cause. Enter UNDERLY			22 72 1 2 2 2										
ËI	that initiated events resulting in death) LAS	т .	DOE 10	(OR AS A CONS	SEQUENCE O	F):								
	3		l											
	PART II. Other significe	nt conditions	contributing to	deeth but no	t resulting	in the u	nderivino	ceuee (oiven in I	Pert i. 24	. WAS AN	ALITOPSY	24h	WERE AUTOPSY FINDINGS
DICAL	Hue		notes								PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	1131		13/1-11							1 (YES 2	XHO		DF DEATH?
Σ∥	DID TOPACCO !!	CE COLITA	IDLITE TO C'	LICE OF F	ATLL ST	·		1 111 1 -						1 TES 2 NO
CIAN	DID TOBACCO U		IBUIL IO CA					UNC	ERTAIN	1				
ᅙ	EXAMINER?	MEDICAL	HOSPITAL:		ACE OF OEA	OTHE	- '							
PHYS	1 YES 2 NO		1 Inpatiant 2		_	4 🗆 Nur	sing Hom	• 5 □ R	aldanca i	8 C Other (Sp				
	~	Pending	28a. DATE OF (Month, D	INJURY ay, Year)	28b. TIM	E OF JURY A M		RK?		28d. OEŞCRI		JURY OCC	CUREO	
à l		Investigation						ES 2 [NO		N/A			
٩		Could not be determined	28a. PLACE O building,	F INJURY — AI etc. (Specify)		atreet, lac	tory, office			281. LOCATIO City or To	N (Street a wn, State)			oute Number,
					N/A							N	/A	
ᆲ	29a. CERTIFIER (Check only	IFYING PHYSIC	XAN: To the best of	my knowledge,	death occurr	ed at the t	lime, data	and place	, and dua	to the cause(s) and man	ner es atet	ed.	
COMPLETED	one) 2 MEDI	ICAL EXAMINER	: On the basis of ex	camination and/e	or Investigation	n, In my o	opinion, d	eath occur	red at the t	time, data and	piaca, and	due to th	a cause(a)	and manner as stated.
U U	29b. SIGNATURE AND TITLE	OF CERTIFIER	Û					29c. LICI	ENSE NUM	BER		29d DATI	F SIGNED /	Month, Day, Year)
∞		2	BNC.	Dh	ueso	for		N	1: /	1170		•	100	20.96
일	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH	TEM 27) (Type	Print)	7	المسالم	4 6	410	·	-	0	20 -12
	7501	U2	RRATA	TY	20	0-	1	7 ^)	01 :	1 19-	rs N I	~	N 3072F
	31. DATE FILED (Month, Day,		32 REGISTRA	R'S SIGNATURE	70.	20	116	200	7,	<u>[</u>	MI	011	(11)	100/27
ŀ	NOV 02		32 REGISTRA	whorks	dall									
	NUV UA	1333	4											

le: TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

31. DATE FILEO (Month, Day, Year)
OCT 3 0 1995

	FOR 1 - STATE REGISTRAR		STATE OF I		/ DEPAR					MEN	ITAL HYGIENI	E		0 4 0 0 =
	1. OECEDENT'S NAME (First,	Middle, Last)			L. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IVA:		DEA	-	2. 0	DATE OF GEATH			3. TIME OF DEATH
()	JASON		TODD			I	MIL	LER	- 0	M	ONTH DA		YEAR	
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. Is	set hirthday)	IF UNDER		IF UNDER	94 MRS	-	TORER OF BIRTH	$\frac{28}{1}$	995	12:45 PM
	213-17-34		1 X M 2 F	16	YRS.	MONTHS	DAYS	HOURS	MIN.	0	Wonth, Day, Year)		Countr	y)
	9a. FACILITY NAME (If not in										6/2/79			MD
m			treet and number)			ı		OR LOCATI	ON OF DE	ATH			O TO OF D	
힏	HARRISON I					B	erli	n				WOR	CES.	rek
DIRECTOR	10a. STATE	10b. COUNTY	Y		10c, CI1	Y, TOWN (OR LOCA	TION		_		-	T	10d, INSIDE CITY
<u>ا چ</u>	MD	Wo	rcester			Ber								LIMITS?
	10e. STREET AND NUMBER	110	T CC3 CC1			Dei		f. ZIP COD	E .	_		10- CITI	76N 05 V	YHAT COUNTRY?
FUNERAL	13 Vine S	+					1,0	2181					USA	
빌	11. MARITAL STATUS		12. WAS DECEDEN	T EVEN IN II C A	DMED	140	W# 0 DC							
립	1 X Never Married 2	Married	FORCES? 1	YES 2 X			If yes, sp	ecity Cubi	ın, Maxica	n, Pu	RIGIN? (Specify Yaa arto Rican, stc.)	or No —	14. RACE Black	— American Indian, c, White, atc.
A	3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DATES			1 YES	2 X NO	Specify	y:		1	Speci	white
	15. DEC	EDENT'S EQU	CATION	16a F	ECEDENT'S	LISUAL O	CCUPATI	ON			16b, KIND OF BUS	INESS/IND	HETEV	
E	(Specify ont	y highest grade	completed)	(Give kind of le. Do NOT u	work done	during me	ost of working	ng		IOD. KIND OF BOS	INESS/IND	OSINI	
12	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Stuc						Stude	ent		
COMPLETED	17. FATHER'S NAME (First, M	liddle (ast)			Juc	CITC		T 18 MOT	HED'S NA	ME /S	irst, Middle, Malden			
	Martin Jol		lor								Lee Co		IKDO	
H	19a. INFORMANT'S NAME (161	L	O		0.00			_				
유	Martin M			Ι,							Number, City or Town		Code)	
									run,		ID 2181			
	20a. METHOD OF DISPOSIT 1 X Burial 2 Crematic 4 Donation 5 Other	n 3 🗆 Ram	noval from State		remetory or or or or or or or or or or or or or					1		cation – Berli	-	
	21. SIGNATURE OF PUNERA	LIGERVICE EX	Bucka	1.		22.		ND ADDRE			Burba t. Berli			ral Home 21811
	23. PART I. Enter the	inganes, dr	complications the	t coused the	death. Do	not enter								Approximate
	shock, of h	eart failure.	List only one pa	se on each ile	ie.									Interval Between
	IMMEDIATE CAUSE (Fit disease or condition	181	Aniti	1015	16	TIK	210	2						Onest and Death
1 1	resulting in death)		a. MUL.	OR AS A CONS	EOUENCE C	DE:	1100	>						
-						,								į
CERTIFICATION	Sequentially list condit		b. DUE TO	(OR AS A CONS	EOUENCE C)F):								
¥	cause. Enter UNDERLY	ING	_											
띮	CAUSE (Disease or injute that initiated events	iry	C. DUE TO	(OR AS A CONS	EOUENCE C	PF):								
틽	resulting in death) LAS	т 📗	11											
빙			0.											
4	PART ii. Other significe	ent condition	ns contributing to	death but not	resulting	in the u	nderiyin	g cause	given in	Part	i, 24a. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
일											1 YES 2			COMPLETION OF CAUSE OF DEATH?
MEDICA											1			1 X YES 2 NO
5	DID TOBACCO U	ISE CONT	RIBUTE TO CA	USE OF DE	ATH Y	ES 🗆	NO [UNC	CERTAI	N [o I			
PHYSICIAN:	25. WAS CASE REFERRED T	O MEDICAL		26. PL	ACE OF DEA	ATH (Check	only one,)						
잃	EXAMINER?		HOSPITAL:	FR/Outpetlant	3 DOA	OTHE		ma € □ B	anldanaa	0 157	Other County (2 N I D	07.01	
ξ	27, MANNER OF OEATH	-	28a, OATE O		28b. TII			JURY AT	ellidenca	4.3	Other (Specify) (OAD	WAY
		Pending	(Month,	Day, Year)		JURY		ORK?	X'NO		RIVER OF			MAVINIM 2
BY	2 Accident	Investigation	10 28	95		,		,	X, NO	-	LOGIZION		المان	
8	3 Suicide 8 Homicide	Could not be determined	building	OF INJURY — At it, etc. (Specify)	O i.d.	Street, fac	tory, otti	CA			City or Town, State)	- 0		
					711-15	2]				111	arrison 1	47. 8	ERL	IN, MARY LOND
COMPL	cond only		ICIAN: To the best o	-										,
0	one) 2XXMED	ICAL EXAMINE	ER: On the heats of	don and/o	r investigati	on, in my	opinion,	death occu	red at the	time	data and place, an	d due to th	na cause(s	a) and manner as stated.
ш	200. SIGNATHRE AND TITLE	OF CERTIFIE	R / M	1	1			29c. LIC	ENSE NU	MBER		29d. OAT	E SIGNEC	(Month, Day, Year)
00		MAL	Sol	eff	W			0	C.M	-		СТО	BED	29.1995
유	30. NAME AND AODRESS O	F PERSON WH	10 COMPLETED CAL	SE OF DEATH (IT	EM 27) (Typ	e, Print)			V = 14	4 1		W. 10	DEK	77,1993
10	MARIO F.	GOL	W JR	MP 1	.11 E	enn	St	reet	. В	al	timore	, Ma	ryl	and 21201

32 REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH	NV.		3. TIME OF DEATH
	3	FEDOR	MIKUS							10	3	ĭ	95	0054
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.		Day, Year)		8. BIRTHP Country)	LACE (State or Foreign
plu		196-24-1184 9s. FACILITY NAME (If not institution, give s		87	YRS.	01.015	-				04-08			UKRAN
3 should	Œ			r (Jeantinean)				OR LOCATI	ON OF O	EATH			ITY OF OE	ATH
1, 2,	ЕСТО	PENINSULA REGIONAL RESIDENCE OF DECEDENT	L MEDICA.	L CENTER		SAL	ISBU	RY				WILCO	MICO	
nit. Pages	DIRE		cester	•	D	COM	12	e C	itu					10d. INSIDE CITY LIMITS? 1 X YES 2 NO
t permit.	RAL	10e. STREET AND NUMBER	0	i			10	7. ZIP COD				10g. CITI	ZEN OF WH	IAT COUNTRY?
physician. burial-transit	FUNER	1311 Princess	HODE	TEVER IN U.S. AR	MED	12	WAS DE	218	51	UC OBION	? (Specify Yes	au No	14. RACE	H
physician burial-trar		1 Never Married 2 X Married	FORCES?	MAR OR DATES		- 3	If yes, sp			n, Pusrto F		OF 140-		- American Indian, White, stc.
attending se as the	ВУ	3 Wildowed 4 Divorced						2 2 2	Ороси	,		1	Ореспу	WHITE
Se	ETED	15. DECEDENT'S EDU (Specify only highest grade		(G	iive kind of	Work done		ON ost of working	ng	16b.	KIND OF BUS	INESS/IND	USTRY	
the hospital or detached for u	PLE	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Do NOT u	à .	00							
the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			CEI	nak	101	18. MOT	HER'S NA	ME (First, A	liddle, Maiden	Surname)		
3 & &	ш		UNKNO	WN							KNOWN	,		
5 should be notified at	TO B	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADORES	S (Street	and Number	or Rural	Route Numb	er, City or Town	n, State, Zip	Code)	
age 5 s	F	Olga Mikus	<u> </u>	13	311 Pr	ince	SS	Jone	2 Lr	1. Po	coma	Ke N	1d. 5	11851
ector, prector, p		20a. METHOD OF DISPOSITION 1 5/ Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from Stats	20b. PLACE. cemetery, cra	matory or o	other place)	10	Park	. Inc	197	20c. LO	CATION -	City or Tow	n, State
death. Pag tuneral dir t. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE					ND ADDRE		d Hor	ne_		~	
n dear		Switt S.	Mels	91		P) P	SOX 6	4. 6	2000	noke	md	. 21	851
or removal.		23. PART i. Enter the diseases, or a shock, or heart failure.	complications the	at caused the de	eath. Do	not antar	tha mo	oda of dy	Ing, suc	h aa card	lac or reapl	ratory arr	eat,	Approximata Intervai Betwee
		IMMEDIATE CAUSE (Final												Onset and Deat
ompletely fille i, cremation, event, the		disease or condition reaulting in death)		OSCLEROT			OVAS	CULA	R DI	SEASI	E .			
			DUE TO	OR AS A CONSE	OUENCE O	IF):								
and and part	ERTIFICATION	Sequentially list conditions, If any, laading to immediate	DUE TO	OR AS A CONSE	OUENCE O	PF):								
# # B C	FIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa	c	OR AS A CONSE	OUENCE O)F):								
attending that Hydron Ay, or oth	H	resulting in death) LAST	4											1
ne death cent the attending Mental Hypi njury, or ot	O	PADT II. Other elgoliticant condition	o.	death has eas		1 - Abril	4.4.1			m: I				
T April	DICAL	PART II. Other algoliticant condition	a contributing to	daath out not i	reauiting	In the ur	idariyin	g cause	given in	Part I.	24s. WAS AN PERFOR		1.0	WERE AUTOPSY FINDING! AVAILABLE PRIOR TO COMPLETION OF CAUSE
signed signed Health a										-	t TYES 2	Х ио		OF DEATH?
1YSICIAN: The law require iis certificate has been sig vith the State Dept. of He ed, or Item 23 shows	Σ	DID TOBACCO USE	CONTRIBUT	E TO CAU	SE OF	F DEA	TH '	YES [1 NC					1 TES 2 NO
e has te Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					26. P			eck only on	p)			
tificat te Sta	YSIC	1 X YES 2 □ NO	HOSPITAL:	ER/Outpatient 3	□ DOA	4 Nur		ne 5 🗆 Re	esidence	8 🗆 Other	(Specify)			
로 등 5 분	>	27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation	28s. DATE Of (Month, I	F INJURY Day, Year)	28b. TIA	ME OF JURY M	W	JURY AT DRK? YES 2	NO NO	28d. DES	CRIBE HOW II	NJURY OCC	CURED	
TOR: A after de 28 is	TED B	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE (building	OF INJURY — At he, etc. (Specify)	ome, farm,	atreet, taci	lory, offic	ce			ATION (Street a or Town, State)	and Number	or Rural Ro	ute Number,
AL DIRE	COMPLE	29e. CERTIFIER (Check only one)												
TO THE HOSPITAL OF TO THE FUNERAL DE filed within 72 ho	Ö	2 K MEDICAL EXAMINE		examination end/or	Investigati	on, in my o	opinion,	death occu	red at the	time, dats	and place, sn	d dus to th	e cause(s)	and menner as stated.
PORT V	BE	29b. SIGNATURE AND TITLE OF CERTIFIE	R						ENSE NUI	MBER				Month, Day, Year)
2 6 3 ₹	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAL	ISE OF DEATH (ITE	MOT /Am	D.M.	.E.	D03	599			10)-31-	95
	,	JOHN T. BULKELEY,					AD.	SAT.Ť	वाप्तर	V. M1	RYT. AN	n. 21	801	
	b	31. DATE FILED (Month, Day, Year)	32. REGISTR	AR'S SIGNATURE			1 /	PULL	אזטכוכ	2. / 1.1E	TT LETA	0 / 23	.001	
)		NOV 0 3 1995	Inha do	indem-Ra	بالعماد									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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hospital or attending physician, izached for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	S.	R: A	er de	.00
	ATE	6	s aft	1 28
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	\vdash	-	9	-

	FOR STATE REGISTRAR	STATE OF MARYLAND / DE	EPARTMENT OF HEALTH A	AND MENTAL HYGIEI		
	1. DECEDENT'S NAME (First, Middle, Lest) Robert	W.	Marshall	2. DATE OF DEATH	DAY 95 YEAR	3. TIME OF DEATH
	400 01 1000	SEX 8. AGE (In yrs. last birt	thday) IF UNDER 1 YEAR IF UNDER 2 YRS. MONTHS DAYS HOURS	MIN. (Month, Day, Year)	220 Count	HPLACE (State or Foreign
OR	90. FACILITY NAME (# not institution, give street PENINSULA REGION		96. CITY, TOWN OR LOCATION SALISBUR	N OF DEATH	9c. COUNTY OF	
DIRECTOR	100. STATE 100. COUNTY Project Accom		C. CITY, TOWN OR LOCATION (Treenback	ville		10d. INSIDE CITY LIMITS? 1 VES 2 NO
FUNERAL	1961. STREET AND NUMBER 1444 Stockton	Avenue	101. ZIP CODE 23	356	10g. CITIZEN OF	SA
₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		HISPANIC ORIGIN? (Specify Yo, Mexican, Puerlo Rican, etc.) Specify:		E - American Indian, k, Whita, etc.
COMPLETED	15, DECEDENT'S EOUCATIK (Specify only highest grade com Elementary/Secondary (0-12)	ollege (1-4 or 5 +) (Give k Ille, Do	ENT'S USUAL OCCUPATION ind of working MOT use retired.) 140 Broker	18b. KIND OF BU	JSINESS/INDUSTRY	
BE COM	17. FATNER'S NAME (First, Middle, Last) William H. M	Parshall		ER'S NAME (First, Middle, Maidel + 1e He	Sumame)	
TO B	Beatrice B. Ma	rshall 144	AILING ADDRESS (Street and Number of 4 Stockton Ave	POBox 96, G	vn. Stete, Zip Code)	We VA.23356
	20s. METHOD OF DISPOSITION 1	from State cemetery, cremate	DATE OF DISPOSITION (Name of bry or other place)	1 1 1/i C	ocation - city or to	own, State
	21. SIGNATURE OF FUNERAL SERVICE LICENS	Melson		neral Home	d. a185	1
		plications that coused the deeth, only one cause on each line.	. Do not enter the mode of dyin	ng, such as cardiac or real		Approximata intervai Between
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	Motatatic DUE TO (OR AS A CONSEQUE		ple		Onset and Death
NOI	Sequentially flat conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUEN	0			
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUE	NCE OF):			
	d					
EDICAL	PART II. Other significent conditions co	minuting to death but not resu	iting in the underlying cause gi		RMED?	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBI	JTE TO CAUSE OF DEATH	YES NO UNCE	RTAIN 🗆		1 TYES 2 THO
SICIA		26, PLACE OF SPITAL:	OTHER: OA 4 Nursing Nome 5 Real	Identify & C. Other (Secretary		
	27. MANNER OF DEATH Natural 5 Pending		b. TIME OF INJURY AT WORK? M 1 YES 2	28d. DESCRIBE NOW	INJURY OCCUREO	
TED BY	2 Accident investigation 3 Suicide & Could not be 4 Homicide determined	28a. PLACE OF INJURY — At home, building, etc. (Specify)	farm, street, tectory, office	281. LOCATION (Street City or Town, State	and Number or Rural I	Route Number,
COMPLETED		: To the best of my knowledge, death of the beals of exemplication and/or invest				e) and manner as stated.
H C	250. SIGNATURE AND 21TLE OF DESTRIPER	MIN	29c. LICEN	ISE NUMBER	29d. DATE SIGNED	(Month, Day, Year)
5	30 NAME AND ADDRESS OF PERSON WHO CO	MPLETEO CAUSE OF DEATH (ITEM 27)	(Type, Print) E. Carroll S	4. Salish	MA	21861
6	31. DATE FILEO (Month, Day, Year) NUV U 6 1995	32. REGISTRAR'S SIGNATURE)	V.11.

		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF H	EALTH AND I	MENTAL HYGIEN REG. NO.					
		1. DECEDENT'S NAME (First, Middle, Last) MARY CAPL		RISON			2. DATE OF DEATH OCT. 31	^{AY} 1995 YEAR	3. TIME OF DEATH 5:20 PM M			
		4. SOCIAL SECURITY NUMBER 224-66-3054	1	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC . 20, 1	8. BIRT	INPLACE (State or Foreign			
3 should	æ	9e. FACILITY NAME (If not institution, give				OR LOCATION OF DE		DEATH				
1, 2,	25	WESLEYAN CENT RESIDENCE OF DECEDENT 100. STATE 100. COUNT		les es		ITON		CA	ROLINE			
permit. Pages	L DIRE		TALBOT	10c. CI1		STON			10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
n. ansit pe	VERAL	221 S. HANSON	ST.		107		601		WHAT COUNTRY? USA			
ding prysician. the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D	2 NO	If yea, spe	ENDENT OF HISPAN scify Cuben, Mexican 2 NO Specify	IC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	se or No— 14. RACE — American Indian, Black, White, stc. Specify: WHITE				
or attend	ETED	15. DECEDENT'S EDU (Specify only highest grad	e completed)	16a. DECEDENT'S (Give kind of life, Do NOT u	USUAL OCCUPATION Work done during mo.	N st of working	16b. KIND OF BUS	INESS/INDUSTRY				
iched for	COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		ARTIST		AR	RTISTRY				
be detached at once.	E CO	17. FATHER'S NAME (First, Middle, Last) EDWARD SUMME	RFIELD CAI	PLES		A	ME (First, Middle, Maiden : BITZER	Surneme)				
thereal director, page 5 should xaminer must be notified	TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING		nd Number or Rural F	loute Number, City or Town					
page 5		MARTHA L. MERZ 200. METHOD OF DISPOSITION	206		S. HAN		, EASTON	CATION — City or T				
director, p		1 Burlel 2X Cremation 3 Ren 4 Donetion 8 Other (Specify) 21. SIGNATURE OF FUNERAL	S2	LISBUR	Y CREMA			ISBURY	, MD			
0 = 0		B. Keith Physm, CFSP NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD										
npletely filled in by the 1 cremation, or removal, vent, the medical ex		23. PART I. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	complications that caused Liet only one cause on a	the death. Do nach line.	not enter the mo	de of dying, such	as cerdiac or respir	ratory arrest,	Approximats interval Between Onset and Death			
5 5 m	_	Tooking in deality	DUE TO (OR AS A	CONSEQUENCE O	F):	0						
sician and cominor to burial, traumatic en	TION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):	4 (0-						
he attending physician Mental Hygiene prior ti Jury, or other traur	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST										
Me Pe	AL CE	PART II. Other significant condition	ns contributing to deeth b	ut not resulting	in the underlying	ceuse given in	Pert I. 24s. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS			
5 5 5	MEDICA						PERFORI		AVAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 WHO			
has bee Dept. o	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YE		UNCERTAIN						
or Item	SICI	EXAMINER? 1 YES 2	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	5 Residence	8 Other (Specify)					
DIRECTOR: After this certificate has been signed hours after death with the State Dept. of Health silem 28 is marked, or Item 23 shows any	ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	JURY WO	JRY AT RK? 'ES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED				
RECTOR: AI	요	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, ferm,	street, factory, office		28f. LOCATION (Street e City or Town, Stete)	nd Number or Rural	Route Number,			
INERAL DIRECTION 72 hours	COMPLET		ICIAN: To the best of my know ER: On the bests of examination						(s) and manner as stated.			
TO THE FUNERAL DE filed within 72 h	TO BE	29b. SIGNATURE AND TITLINGS CERTIFIE	mue			29c. LICENSE NUM	1036	D 11/	(Month, Day, Year)			
	-	Gan S	O COMPLETED CAUSE OF DE	2108	Print) D. Dr	ate Du	L COOL	e_M)	21613			
		31. DATE FILED (Month, Day, Year) NOV 02 199	32. REGISTRAR'S SIGN	r Randall								

1.30

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

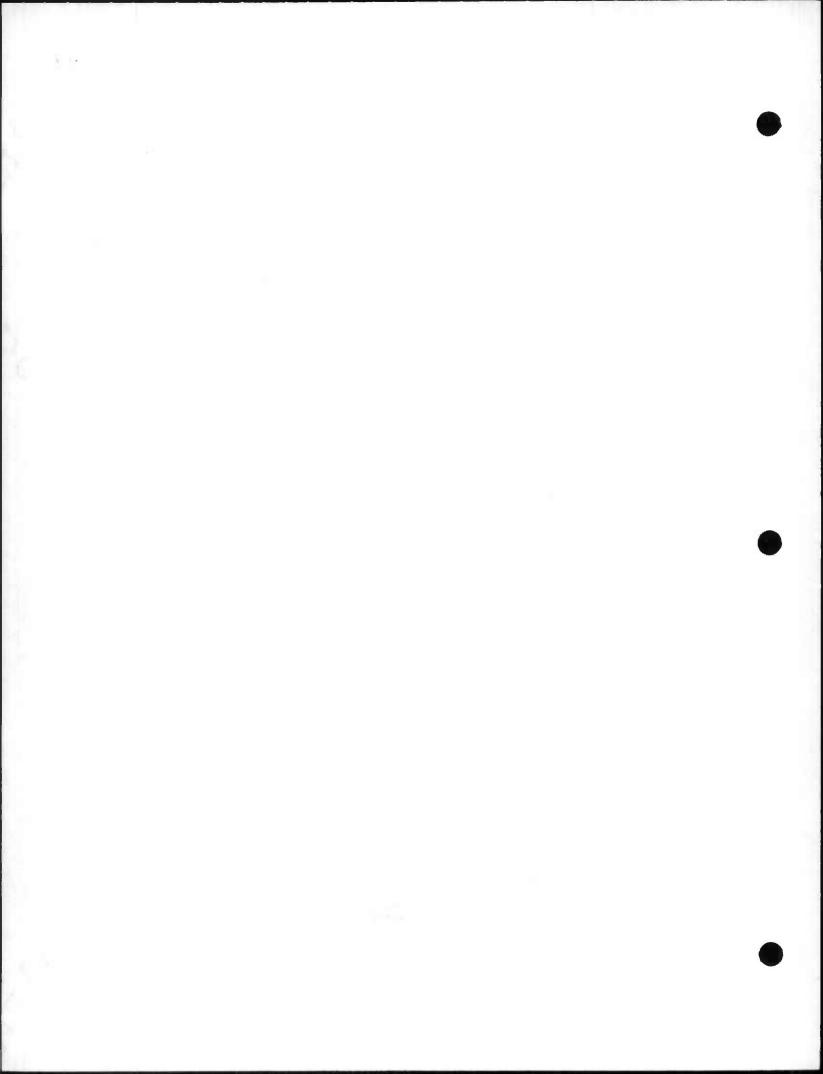
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF REGISTRAR	MARYLAND / DEP. CERT	ARTMENT OF HEA		NTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last) ETHEL BARCU	s MC	OORE		DATE OF OEATH	1995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. last birthde	MONTHS DAVE M	F UNDER 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign
	218-34-9751 1 M 2XXF 9a. FACILITY NAME (If not institution, give street and number)	80 YRS	96. CITY, TOWN OR I	F	EB. 16.		ARYLAND
DIRECTOR	620 OWENS ROAD			ANNE'S			
REC	10a. STATE 10b. COUNTY		CITY, TOWN OR LOCATION	i			10d. INSIDE CITY
	MARYLAND QUEEN ANNI	i's	CENTREY	VILLE P COOE			1X YES 2 NO
FUNERAL	209 HOLLY STREET		7877	21617		USZ	F WHAT COUNTRY?
FUN		HT EVER IH U.S. ARMEO		DENT OF HISPANIC (y Cuban, Maxican, P	ORIGIN? (Specify Yes	or No.— 14. BA	CE — American Indian, ack, White, etc.
ВУ	3€ Wildowed 4 □ Divorced IF YES, GIVE	WAR OR DATES		MO Specify:			white
TED	15. DECEOENT'S EDUCATION (Specify only highest grade completed)	(Give kind	T'S USUAL OCCUPATIOH of work done during most of	f working	16b, KIND OF BUS	HESS/INDUSTRY	
COMPLET	Elementary/Secondary (0-12) College (1-4 or 8	1+)	USEWIFE		OW	N HOME	
CO	17. FATHER'S NAME (First, Middle, Last)			. MOTHER'S NAME	(First, Middle, Maiden		
BE	JAMES WILLIAM BARCUS		WO 455555 (C)	ALICE	DEGET		
5	WEBSTER FRANKLIN MOOR		8 FOGWELI				MD 21617
	20s. METHOO OF DISPOSITION Description	20h. PLACE AND DA	TE OF DISPOSITION /Name	of	0ATE 200 LOC	CATION - CIty of	Town State
	21. SIGNATURE OF FUHERAL SERVICE LICENSEE	_ CHESTER	FIELD CEM	ETERY I	11-3 CEN	ITREVII	LE, MD
	YOHN R. MERC	E257 (NEWNAM		AL HOME,		NAT ASID
	23. PART I. Enter the diseases, or complications the shock, or heart fellure. List only one ce	at ceused the death. D	D not enter the moda	of dying, auch as	s cardiac or raspir	ratory arrest,	Approximats
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	static rena		1 to le	mg		Interval Between Onset and Death
Z	- Respect	O (OR AS A COHSEQUENCE	OFICINON	~			1989
ET S	It sny, leading to immediate	OR AS A CONSEQUENCE					1.07
FIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	O (OR AS A CONSEQUENCE	OF):				
CERTIFICATION	resulting in death) LAST						
AL C	PART II. Other significant conditions contributing to	o death but not resulting	g in the underlying ca	tuse given in Par			1b. WERE AUTOPSY FINDINGS
DIC					t TYES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	DID TOBACCO USE CONTRIBUTE TO CA	ALISE OF DEATH	VEC TO NO ET	IN ICEDIAN I	_		1 TYES 2 HO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		EATH (Check only one)	UNCERTAIN [
YSIC		☐ ER/Outpatient 3 ☐ DOA		Residence 6 🗆	Other (Specify)		
ВУ РН	1 Pending		I'IME OF 28c. IHJURY WORK? M 1 YES	2 HO 28	d. DESCRIBE HOW IN	JURY OCCURED	
	3 Suicide 6 Could at he 26s. PLACE	OF INJURY — At home, farm I, atc. (Specify)	n, street, factory, office	261	I. LOCATIOH (Street as City or Town, State)	nd Humber or Rura	l Route Humber,
COMPLETED	29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of						
CON	one) 2 MEDICAL EXAMINER: On the basis of	examination and/or investige	ntion, in my opinion, death	occured at the time	e, data and place, and	I due to the cause	o(a) and manner as stated.
) BE	Much all X 000 M)	29	c. LICEHSE HUMBER	105	29d. DATE SIGHE	3/19
2	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAN	ISE OF DEATH (ITEM 27) (7)	Easto	2 11	- /	(0)	
		AR'S SIGHATURE	C4310	16 100	216	001	
	NOV 01 1995 Tali d	widear Revolath					

		REGISTRAR				EHILL	ICALE	: OF	DEATH		REG. NO).		
		1. DECEDENT'S NAME (First, Mid	idle, Last)								ATE OF DEATH		3	. TIME OF DEATH
		CLAYTON F.	MOSS	SER							VEMBER	3. 19	YEAR Q5	4:15 A M
5-0020 anding physician. as the burial-transit permit. Pages 1, 2, 3 should		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. las	si birthday)	IF UNDER	1 YEAR	IF UNDER 24 H	RS. 7. C	ATE OF BIRTH	J, 17		ACE (State or Foreign
		219-14-6427		1 📉 M 2 🗌 F	78	YRS.	MONTHS	DAYS	HOURS MI	M (forth, Day, Year) 1g 28, 1	017	Country)	
								TOWN /	OR LOCATION C		ly 20, 1			4D
	CC	SC COUNTY OF DEATH												
	СТОВ	RESIDENCE OF DECED		KUAD			. 02	AKLA	MD			G.F	ARRET	<u>r</u>
98 1			. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION				10	Dd. INSIDE CITY
Pag	DIREC	MD	Garr	o++		02	kland	4					1.75	LIMITS?
Ĭ.		10a, STREET AND NUMBER	OULL			<u>J</u> Oa	X LOUR	_	f. ZIP CODE			T is a		YES 2 NO
- FE	FUNERAL													AT COUNTRY?
ian. trans	2	1559 Gnegy C	hurc						21550			USZ		
20 lysic urial-	교	1 Never Married 2 Marr	ried	FORCES? 1	IT EVER IN U.S. AF YES 2 1 WAR OR DATES	NO NO	13. 1	MAS DEC 1 yes, sp	ENDENT OF HI ecity Cuban, Mi	SPANIC OF exican, Pur	IGIN? (Specify Yearto Rican, etc.)	s or No-	14. RACE — Black, V	- American Indian, Vhita, etc.
5-0020 nding physic as the burial	B	3 Widowed 4 Divorced					1	YES	2 XNO S	pecify:	,	ľ	Specify:	
as t	0	15. DECEDE	NT'S FOLIC	WW I		AFRENTIA								nite
121 or after	E	(Specify only high			/G	CEDENT'S live kind of v Do NOT us	vork done o		ON osl of working		16b. KIND OF BU	SINESS/IND	USTRY	
21 oital or of for u	121	Elementary/Secondary (0-12)		College (1-4 or 5	*'					-	~ 3	- 1		
AND the hospita detached it	COMPL	12			R	etire	<u>a</u>						ıstrie	es
A a a		17. FATHER'S NAME (First, Middle,							18. MOTNER'S	S NAME (F	rsi, Middle, Maiden	Surname)		
RYL M by	빎	Earl Moss							Mau	ıde (Spitzer)		
; MARYLAND 21215-0020 be retained by the hospital or attending physician. ge 5 should be detached for use as the burial-tran	6	19a. INFORMANT'S NAME (Type/F	Print)		19	b. MAILING	ADDRESS	(Street a	and Number or R	lural Route	Number, City or Tow	rn, State, Zip	Code)	
E, N y be re bage 5	-	Darlene K. J	Jacks	on	1	559 0	neav	Chi	urch Ro	oad:	Oakland	, MD	2155	0
RE, may be r, page		209 METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3	Remo	and from State	20b. PLACE	AND DATE O	F DISPOS						City or Town	, Stata
FOR marketor, prestor		4 Donation 5 Other (Spe	c/fy)	vai irom state	camelery, cre	Tohn'	her place)	the	ran Cen	1	1/05 Re	ed Hou	ise, M	ID
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.	1	21. SIGNATURE OF FUNERAL SE	RVICE LICE	ENSEE 1	/	10			ND ADDRESS O	1				
AL leath funer	1 1	* Ulink	Yla	$\Lambda \perp \lambda_{I}$	anim	11;					al Home			
BALTIMORE rs after death. Page 6 may n by the funeral director, pa removal.			KU	04.24	MORE	n	C	umbe	erland,	MD.	21502			
in les	Н	23. PART I. Enter the disease shock, or heart	ses, or co	ompligations the	it caused tha de use on each line	eath. Don	ot antar	the mo	da of dying,	auch as	cardiac or resp	iratory arre	est,	Approximate interval Between
		IMMEDIATE CAUSE (Final												Onset and Death
F de la la la la la la la la la la la la la		disease or condition resulting in death)	a	METAST	ATIC PRO	OSTAT	E CA	NCE	R					1YEAR
control of the completely or burial, crematic event, if				DUE TO	(OR AS A CONSE	DUENCE OF	7):							
6876 precuted and com burial,		Commentally, list on addition	-	<u> </u>										
OX 68 be execut sician and chor to bunit		Sequentially list conditiona if any, leading to immediate		DUE TO	(OR AS A CONSE	DUENCE OF):							
BOX ficate be a physician a ne prior to	3	cause. Enter UNDERLYING CAUSE (Disease or Injury	2 .											
Certificat nding phy Hygiene p	E	that initiated events		DUE TO	(OR AS A CONSE	DUENCE OF	7:							
O. T. B. P.	1 # 1	resulting in death) LAST	d											
the death the atter the atter Mental		PART II. Other significant c	onditions	contribution to	dooth but not a	a a seleta a se	n the con	al a aladia	e easter allies	I Do			1	
A se of the							n the un	aeriying	g cause giver	in Part	. 24a. WAS AN PERFOR		AN	ERE AUTOPSY FINDINGS WILABLE PRIOR TO
Signed by Health an Ws any	ă	CORONARY	ARTE	RY DISEA	SE, COP	D					1 🗆 YES 2	ON		OMPLETION OF CAUSE F DEATH?
REC requires seen sign of Heal													11	YES 2 NO
AL RE e law requent has been Dept. of 23 sho	ż	DID TOBACCO USE	CONTR	IBUTE TO CA	USE OF DEA	TH YE	1 🗆 S	10 ₹	UNCERT	AIN [
F VITAL SICIAN: The law certificate has to the State Dept or Item 23	SICIAN:	25. WAS CASE REFERRED TO ME EXAMINER?	DICAL		26. PLAC	E OF DEAT								
AN: The An: The tifficate is State	Sic	1 TYES 2 TONO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nurs		o 5 (XPanider	nca 8 🗆 i	Other (Specify)			
Sicia Sicia in the	TI	27. MANNER OF DEATN		28a. DATE OF		28b. TIM	E OF	28c. INJ	URY AT	-	DESCRIBE HOW I	NJURY OCC	URED	
NG PHYS frer this cast with		1 Natural 5 Pend	ling itigation	(Month, D	ay, Year)	INJ	M		RK? YES 2 NO					
ON VDING : After death		2 Calatta		28a. PLACE O	F INJURY — At ho	me, farm, s	treet, tacto	ory, office		28t.	LOCATION (Street	and Number	or Rural Boul	a Number
S after afte			mined	building,	atc. (Specify)						City or Town, State)		pr vigrar ribus	
S S S S S S S S S S S S S S S S S S S		29a. CERTIFIER												
TAL CALL	₩ P	(Check only		IAN: To the beat of										
TO THE HOSPITAL (TO THE FUNERAL D De filed within 72 h MPORTANT: If 18	COMPLET	2 MEDICAL	CAMINER	: On the basis of a	xamination and/or i	Investigation	n, In my o	pinion, d	eath occured at	the time,	deta and placa, ar	id dua to the	ı cause(a) ar	nd menner as stated.
THE HOSP! THE FUNEF	BE (HIS. SIGNATURE AND TITLE OF	CERTIFIER,	1/				- 1	29c. LICENSE	NUMBER		29d, DATE	SIGNED (M	onth, Day, Year)
1668 8		//	on	m					D33	3464		•	11/03	/95
(0	일	30. NAME AND ADDRESS OF PER	SON WHO	COMPLETED CAUS	SE OF DEATN (ITE	M 27) (Type,	Print)							
110		Dr. ROBERT M	COII	GHLIN	РО ВОХ	EGI	ON	WV ?	26716					
1000		31. DATE FILED (Month, Day, Year)	1-10		R'S SIGNATURE		J11)	** ¥ Z	-0/10					
	1 1	NOV 0 8 19	95	Status at and	MON HONORA	Eli								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 2, 200, 11/9/95, Md.S., Cellegany Co.

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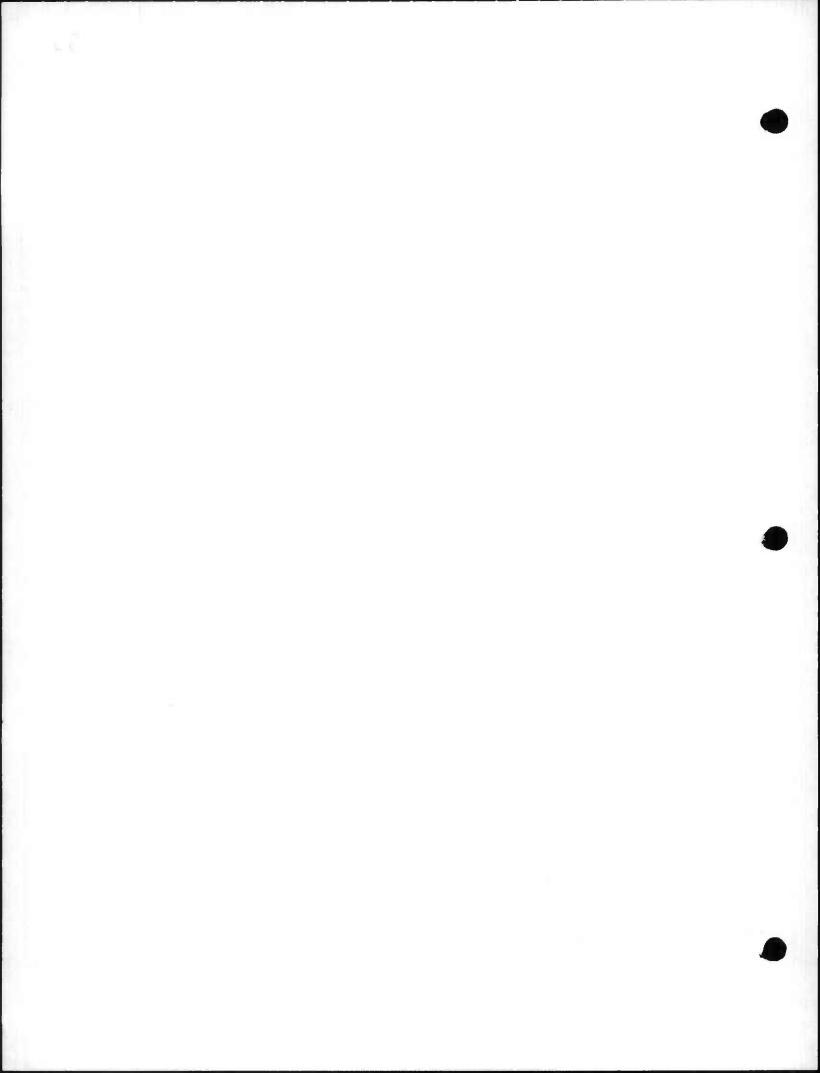
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	REGISTRAR		CERTIF	-ICALE (F DEATH	RE	G. NO.		
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	EATH		3. TIME OF GEATH
	EUGENE GRIFFIT	T MOODE				MONTH		9 SEAR	000 a
	4. SOCIAL SECURITY NUMBER					NOV			N M
	4. SOCIAL SECURITY NUMBER		VGE (In yrs. lest birthday)	IF UNDER 1 YE		7. DATE OF BII	RTH Year)	8. BIRTHS Country	PLACE (State or Foreign
	220-22-9962	1 □ M 2 □ F	68 YRS.	MONTHS DA	YS HOURS MIN.	Sep 7,	1927	_	WV
	9e. FACILITY NAME (If not institution, give st	reet and number)		96, CITY, TO	WN OR LOCATION OF D		- T	UNTY OF OE	
œ	701 EDEDEDICK CO	חיבויבורוו			ERLAND		0.00	LLEGA	
임	701 FREDERICK ST	REET		CUMB	CKLAMD		A		INY
DIRECTOR	10e. STATE 10b. COUNTY		10c CI	TY, TOWN OR LO	CATION				404 110105 0171
<u>E</u>					The state of				10d. INSIDE CITY LIMITS?
		egany	C	umberla	ınd				1 XYES 2 NO
4	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CI	TIZEN OF W	HAT COUNTRY?
E	701 Frederick St	reet			21502		U	SA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13 WAS	DECENOENT OF HISPA	NIC ODIGIN2 (So	cify Van ay No.	T 14 BACE	- American Indian,
	1 Never Married 2 Merried	FORCES? 1 1	YES 2 NO	If yes	, specify Cuban, Mexic	an, Puerto Rican,	atc.)	Black,	White, atc.
A	3 Widowed 4 Divorced	IF YES, GIVE WAR O	OR DATES	1 0	YES 2 THO Speci	fy:		Specifi	white
	45 0505050410 5010			1					WILLCE
H	15. OECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT: (Give kind of	work done during	PATION most of working	16b. KIND	OF BUSINESS/IP	IDUSTRY	
3	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	use retired.)		i i			
4	12		Retir	:ed		Te	elephon	e Com	pany
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle,	Malden Sumame)		
0	Elden Crowe					leen (M			
BE	19a, INFORMANT'S NAME (Type/Print)		105 MAILIN	O ADDRESS (Co.					
2	(,),		1		eet end Number or Rural				
	Evelyn F. Moore		701 E	rederi	ck Street;	Cumber	cland, N	1D 2J	1502
	20a. METHOD OF DISPOSITION 1. Suriel 2 Cremation 3 Remo	neal from State	20b. PLACE AND DATE cemetery, crematory or		N (Name of	DATE	20c. LOCATION	- City or Tow	vn, State
	4 Donation 5 Other (Specify)		Sunset M		1 Park	11/11	. Cumbe:	rland	, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	11		E AND ADDRESS OF FA				-
ļ		100	0 11/1	Sc	arpelli Fu	neral E	Tome		
	yunes 1 x	Very	XU/Gr	Cun	mberland.	MD 215	502		
	23. PART i. Enter the diseases, or c	omplications that car	used the deeth. Do	not enter tha	mode of dying, aud	ch as cerdiac o	r respiratory a	rreat,	Approximata
	ahock, or heart feilure. I	lat only one cause o	on each lina.						interval Between
- 1	IMMEDIATE CAUSE (Final disease or condition	111/11/	LAIMAL	1 1	X100-	VIOLT			Onset and Death
	resulting in death)	1. /VIYUC	VI MIV	- 110	PAIC	17071			5 111
		DUE TO (OR	AS A CONSEQUENCE	DF):	CARRIA	MACC	JAn.	- IC DO	-11 111XX
Z	Sequentially list conditions,	H16 1511	10) CL F/	0710	CHILDIV	0736	ULAIL	Duzh	4 18 10
CERTIFICATION	if any, leading to immediata	DUE TO (OR	AS A CONSEQUENCE	OF):					
3	cause. Enter UNDERLYING CAUSE (Disease or Injury								
E	that initiated events	DUE TO (OR	AS A CONSEQUENCE	OF):					
듄	resulting in death) LAST								
빙									
ا بر	PART ii. Other algnificent conditions	contributing to dear	th but not resulting	in the under	ying ceuse given in	Part t. 24a.	WAS AN AUTOPS		WERE AUTOPSY FINDINGS
EDICAL						1	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
						''	YES 2 NO		OF DEATH?
Σ									1 NES 2 NO
PHYSICIAN: M									
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			B. PLACE OF DEATH (CI	neck only one)			
S	1 TYES 2 NO	1 Inputient 2 ER/	Outpatient 3 DOA	OTHER:	Home 5 Reeldence	6 Other (Spec	offy)		
ΞI	27. MANNER OF DEATH	26e. DATE OF INJU		ME OF 28c.	INJURY AT		HOW INJURY O	CCURED	
	1 Natural 5 Pending	(Month, Day, Ye	ar) IN	JURY M 1	WORK? YES 2 NO				
à	2 Accident Investigation	260 BLACE OF IN	IURY — At home, ferm,						
	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Specify)	atreet, rectory,	omice	City or Town	(Street end Numb n, State)	ar or Rural Ric	oute Number,
E 1									
7 1	290. CERTIFIER 1 GERTIFYING PHYSIC	CIAN: To the best of my k	nowledge, death occur	red at the time,	date and place, end due	to the cause(s)	and mariner as at	ated.	
Ξ		T: On the basis of examin							and manner as stated
COMPLETED				.,, оримо				···s canadía)	end menner en stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	MAN	OA. x	,	29c. LICENSE NU	MBER	29d. DA	TE SIGNED	(Month, Day, Year)
	Mary Mary	1711)	11/17	,	1004)))	> /	1)	45
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (Typ	e, Print)			-		
	DOUALD NAM	VOER	1442) HA	ZEN VD	NE	CUMB	BNU	MOMO
	NOV 0 9 1995	62 REGISTRAR'S	SIGNATURE						



31. DATE FILED (Month, Day, Year)
NOV 0 7 1995

FOR STATE REGISTRAR

ALTCE

1. DECEDENT'S NAME (First, Middle, Last)

5. SEX

4. SOCIAL SECURITY NUMBER

	1 2	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE	(In yrs. last	birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.		OF BIRTH	
		215-14-6196		1 □ M 2 🂢 F	74	1	YRS.	MONTHS	DAYS	HOURS	MIN.	Jul	29 1	
1, 2, 3 should		Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OR											20, 1	
	5	MEMORIAL HOS	PITAL	& MEDIC	AT. C	ENTE	R	CUMI	REDI	AND				
	DIRECTOR	RESIDENCE OF DEC		- HEDIO	.12 0	DIVI I		COM	TEICE	JAND	-	_		
sedi	Ä	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION												
£	<u>=</u>	MD Allegany Cresaptown												
permit. Pages 1,	A	10e. STREET AND NUMBER							7	ZIP COOL	E			
75	8	12810 McKay	Driv	e SW					12	1502)			
_AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit	FUNERAL	11. MARITAL STATUS	DI IV	12. WAS DECEDER				13. W				VIC ORIGI	N? (Specify Y	
Phys buri		1 Never Married 2 💢 I		FORCES?		2XN	0			city Cuba 2 X NO	in, Maxica Specif		Rican, etc.)	
as the	BY	3 Widowed 4 Divon	ped							29				
21215-0020 al or attending physic for use as the burial	COMPLETED	15. DECE (Specify only	DENT'S EDU	CATION completed)				USUAL OCC			-0	16	. KIND OF BI	
21 P Q	<u> </u>	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Cive kind of work done during most of working life. Do NOT use retired.)									·v			
Spit Shed	<u> </u>	12 Homemake											Own H	
YLAND by the hospit be detached	Ö	17. FATHER'S NAME (First, Mic	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, 1											
Z > 2 7		John Nea	<u></u>							L	oret	ta (Higgin	
MARYLAND retained by the hospital 5 should be detached	B	19a. INFORMANT'S NAME (Ty	oe/Print)			19b	MAILING	ADDRESS (Street ar				ber, City or To	
≥ e - e - e	2	Thomas L. M	lorgan			12	810 1	McKav	Dr	ive	STAT .	Cro	sapto	
AE, page		20s. METHOD OF DISPOSITIO	N			. PLACE A	ND DATE O	F DISPOSITI			Ditt	OAT		
OR may ector, p		tX Buriel 2 Cremation 4 Donation 8 Other		oval from Stata			Gan	her plece) Vete:	ran	c Co	m	11/	06 Fl	
		21. SIGNATURE OF FUHERIAL	SETVICE LIC	ENSEE			Vap	22. NA	ME AN	D AODRE	SS OF FA	CILITY		
death. Page tuneral di		Minh	1) 1	1 1	· ^ ^	M	1)-	Sca	arp	elli	Fun	eral	. Home	
		MUL	RUL	11. DK	u_{1}	Y LL	ll	Cur	mbe:	rlan	d, M	D 2	1502	
5 - 5 5		23. PART i. Enter the dis shock, or he	eeses, or o	compilections the	it ceuse use on e	d the dec	eth. Do n	ot enter th	ne mod	de of dyl	ing, suc	h ss cer	diec or resp	
		IMMEDIATE CAUSE (Fins		,										
within 24 pletely fille cremation,		disease or condition resulting in death)	>	CONGEST	IVE	HEAR	T FA	ILURE						
s76C nted within completely ial, cremati		DUE TO (OR AS A CONSEQUENCE OF):												
coecuted wind and comple or burial, creaming the matter and complete a		Sequentially list conditions, MITRAL VALUE REGURGITATION												
	CERTIFICATION	if any, leading to immediate												
BOX cate be ex thysiclan a	5	CAUSE (Disease or injury CORNARY ARTERY DISEASE												
on plane	쁜	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
death certificate attending physiental Hygiene private the transfer to the tra	H	resolding in death) LAST		d										
0 4 2 3		PART II. Other aignificer	t condition	a contributing to	death b	out not re	suiting i	n the unde	erivina	COURS C	aiven In	Part i	24a, WAS A	
ORE that the the ed by 1 and h and and in the ed by 1 and h and in the ed by 1 and in the	MEDICAL	PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. HYPOMATREMIA										PERFO		
signed Health a			-11									_	1 TYES	
RECC requires sen sign of Healt	Σ	HYPOXIA												
Taw law	AN:	DID TOBACCO US		RIBUTE TO CA	USE C					UNC	ERTAI	1 🔀		
TA The The sate had a pare to the control of the co	1 5 1	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL	HOSPITAL:		26. PLACI	E OF OEAT	H (Check on	y one)					
CIAN: ertifica the Str	YSI	1 TES 2 NO		1 3 Inpatient 2	ER/Out	patient 3	□ DOA	4 Nursin	g Home	5 🗆 Re	aldenca	8 🗆 Oth	er (Specify)	
		27. MANNER OF DEATH		28a. DATE OF (Month, L			26b. TIME	URY 2	Bc. INJL WOF	IRY AT		28d. DE	SCRIBE HOW	
ON OP OING PHYS After this death with	B	1 🔀 Natural 5 🗌 P 2 🗌 Accident Ir	ending vestigation					М	1 🗌 Y	ES 2 [NO	_		
		3 Suicide 8 C	ould not be	28e. PLACE C building.	of INJURY	— At hor	ne, ferm, a	treet, factory	, office				ATION (Street or Town, State	
DIVISION L OR ATTENDING F DIRECTOR: After hours after death		4 Homicide d	etermined	40 454 2.0								J.17	- Tourn, Grane	
DIV L OR A DIREC hours	COMPLET	29a. CERTIFIER 1 CERTI	YING PHYS	CIAN: To the best of	my know	fedge, des	ith occurre	d at the time	e, dete	and place.	, end due	to the ce	use(a) and ma	
4 3 2 E	M	onel	1	R: On the leade of a	200	1								
E HOSPIT E FUNER d within 7	ၓ	29b. SIGNATURE AND TITLE	1/	ΔI	-/	0.1/1	100				ENSE NUI			
무 무 형 등	l W	,	17	VY /	_				- 1	ANG. LICE	MOE NUI	HUER		

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

VIK POONAI M.D., 955 FREDERICK STREET, CUMBERLAND, MD

32. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

MORGAN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR NOVEMBER 1995 4:30 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 921 MD 9c. COUNTY OF DEATH ALLEGANY 10d. INSIDE CITY LIMITS? 1 YES 2X NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE - American Indian, Black, White, etc. white USINESS/INDUSTRY Iome n Sumama) wn, State, Zip Code) Wn, MD 21502 OCATION — City or Town, State intstone, MD piratory errest, Approximate Interval Between **Onset and Death** 2 MONTHS 3 YEARS 8 YEARS 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE N AUTOPSY PRMED? 2 NO OF DEATH? 1 - YES 2 - NO INJURY OCCURED and Number or Rural Route Number, anner ea atated. and due to the cause(s) end manner ee stated. 29d. DATE SIGNED (Month, Day, Year)

Nomber 11,1998

D 36766

1 - FOR STATE REGISTRAF

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		С	ERTIFIC	CATE	OF DEATH	REG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEAT	H DAY	YEAR 3	. TIME OF DEATH	
	ELIZABETH LEE 4. SOCIAL SECURITY NUMBER	MINA					NOVEMBE!			7:05 A M	
	213-38-8662	5. SEX 6.	AGE (In yrs. le	**	IF UNDER 1 YE.		7. DATE OF BIRTH (Month, Day, Yea JULY 19,	r)	8. BIRTHPL Country) W.	ACE (State or Foreign	
DIRECTOR	9s. FACILITY NAME (If not institution, give					WN OR LOCATION OF D	EATH		NTY OF DEAT	тн	
	GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT										
	10a. STATE 10b. COUN	TY		10c. CITY,	TOWN OR LO	OCATION			11	Dd. INSIDE CITY	
	MARYLAND GAR	RETT		OAF	KLAND				LIMITS?		
	142 N. SECOND ST	REET				101, ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA			
CINELINE	tt. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AI	RMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specif	Yas or No-	14. RACE -	- American Indian,	
COMPLETED BY FUNI	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR	OR DATES	NO		ii, specify Cuban, Maxico YES 2500 NO Specif)	Specify:	WHITE	
	15. DECEDENT'S ED (Specify only highest grad		/(ECEDENT'S US	rk done during	PATION g most of working	16b. KIND OF	BUSINESS/IND	USTRY		
	Elementary/Secondary (0-12) College (1-4 or 5 +)			OMEMAE	retired.)			OWN HOM	(E)		
	12 t7. FATHER'S NAME (First, Middle, Last)			OFILFIAI	CLIC						
ا <u>ت</u>	DWIGHT L. ASHB	Y				MARGU	ME (First, Middle, Ma ERITE M		BELL		
۱۵	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING A	DDRESS (Str	eet and Number or Rural					
2	MARGUERITE DILLE	Y		600 D	LLLEY	ROAD OA	KLAND, MD 21550				
	20s. METHOD OF DISPOSITION t \(\tilde{\Delta} \) Burisl 2 \(\tilde{\Delta} \) Cremstlon 3 \(\tilde{\Delta} \) Rer 4 \(\tilde{\Delta} \) Donstlon 5 \(\tilde{\Delta} \) Other (Specify)				TEOF DISPOSITION (Name of CEMETERY DATE 20c. LOCATION — City or Town, State OAKLAND, MARYLAND						
	21. SIGNATURE OF THERAL SURVICE L	CENSEE	4		22. NAM	E AND ADDRESS OF FA	CILITY	P.O. BC	X 243		
	M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Metastat		rcinos	arcom	a of Endon	netrium			Interval Between Onset and Death 4 month	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):										
EDICAL	Peptic Ulcer Disease, Sigmoid Diverticulosis									MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
∑	DID TOBACCO USE	CONTRIBILITE	TO CAL	ISE OF	DEATH	YES I N		C	1	YES ZY NO	
AN:	25. WAS CASE REFERRED TO MEDICAL	T	TO CA	JUL 01		8. PLACE OF DEATH (C)	7-4				
SICI	EXAMINER?	HOSPITAL:	3/Outpatient :		THER:	Home 5 - Residence					
PHY	27. MANNER OF BEATH	28a. DATE OF INJ	IURY	28b. TIME	OF 28c.	INJURY AT	28d. DESCRIBE H	OW INJURY OCC	CURED		
1 2	t Natural 5 Pending Investigation	(Month, Day, 1	rear)	INJUF		WORK? YES 2 NO					
TED B	•	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street, tactory, office building, stc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, tactory, office building, stc. (Specify)									
MPLE		SICIAN: To the best of my	knowledge, de	eath occurred	at the time,	dats and place, and dus	to the cause(s) and	menner as stat	ed.		
5	one) 2/ MEDICAL EXAMIN	ER: On the basis of sxam	ination and/or	Investigation,	in my opinio	on, death occured at the	time, date and place	s, and dus to th	e cause(s) si	nd menner as stated.	
ш	29b. SIGNATURE AND TITLE OF CERTIFIE	A A I	1 -	,	7	29c. LICENSE NU	MBER	29d. DAT	E SIGNED (M	lonth, Day, Yesr)	
2	Villegati	244	elki	1		D2665	0	1	1/13/9	95	
	30. NAME AND ADDRESS OF PARSON W Margaret A. Kaise		or 486		_{rini)} kland	MD 21550)				
	31. DATE FILE(I (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE	-							
	NOV 1 3 199	35	Jun 1	was							

YEAR

1995

9c. COUNTY OF DEATH

USA

Garrett

10g. CITIZEN OF WHAT COUNTRY?

Specify:

3. TIME OF DEATH

6:40 P.

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 NO

White

intarvai Batwo

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Onset and Death

B. BIRTHPLACE (State or Foreign West Virginia

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH ohn William Sr. Nov 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday, 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 85 YRS. DAYS 233-48-5638 1 🛛 M 2 🗌 F 5-5-1910 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH RECTOR Pages 1, 2, 3 Garrett County Memorial Hospital 0akland RESIDENCE OF DECEDENT 10a. STATE FLORIDA 10b. COUNT 10c. CITY, TOWN OR LOCATION COLLIER ō Proston Terra Alta permit. **BONITA SPRINGS** FUNERAL 100. STREET AND NUMBER 4895 BONITA BEACH RD. APT. 303 10f. ZIP CODE 100 Toy Street 26764 director, page 5 should be detached for use as the burial-transit 33923 Page 6 may be retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12 Business Man Car Dealer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 7 Oda Roth C. E. Markwood BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Kitty Lou Hill P. O. Box 553 Kingwood, WV 26537 2 20s. METHOD OF DISPOSITION
1X Burial 2 Cremetion 3 Ren 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must 4 Donation 5 Other (Specify) Terra Alta Cemetery 11-17-95 Terra Alta, W.VA. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE the medical examiner Arthur H. Wright Funeral Home, Inc. the attending physician and completely filled in by the funeral Mental Hygiene prior to burial, cremation, or removal. hours after death. white Corthur 105 Highland Ave. Terra Alta, WV 26764 or removal. 23. PART I. Enter the disesses, or complications that caused the desth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart fallure. List only one cause on each line **IMMEDIATE CAUSE (Finel** disease or condition resulting in death) yocarden event, executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 rosclero fir traumatic CERTIFICATION VOSC, RES Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate The law requires that the death certificate be cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury. PART II. Other significent conditions contributing to death but not reaulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY signed by the any 1 TES 2 NO been 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: DR ATTENDING PHYSICIAN: 1 TES 2 NO estient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? this c marked. 1 Natural 2 Accident Day Year) 5 Pending 1 YES 2 NO BY After 28a. PLACE OF INJURY - At home, farm, street, factory, office 3 Suicide 8 Could not be DIRECTOR: / COMPLETED 1 (Sp 4 Homicide 28 determined Hem 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITAL D
TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If its 2/ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1104 DHMH-16 Rev 1/89

BE

2

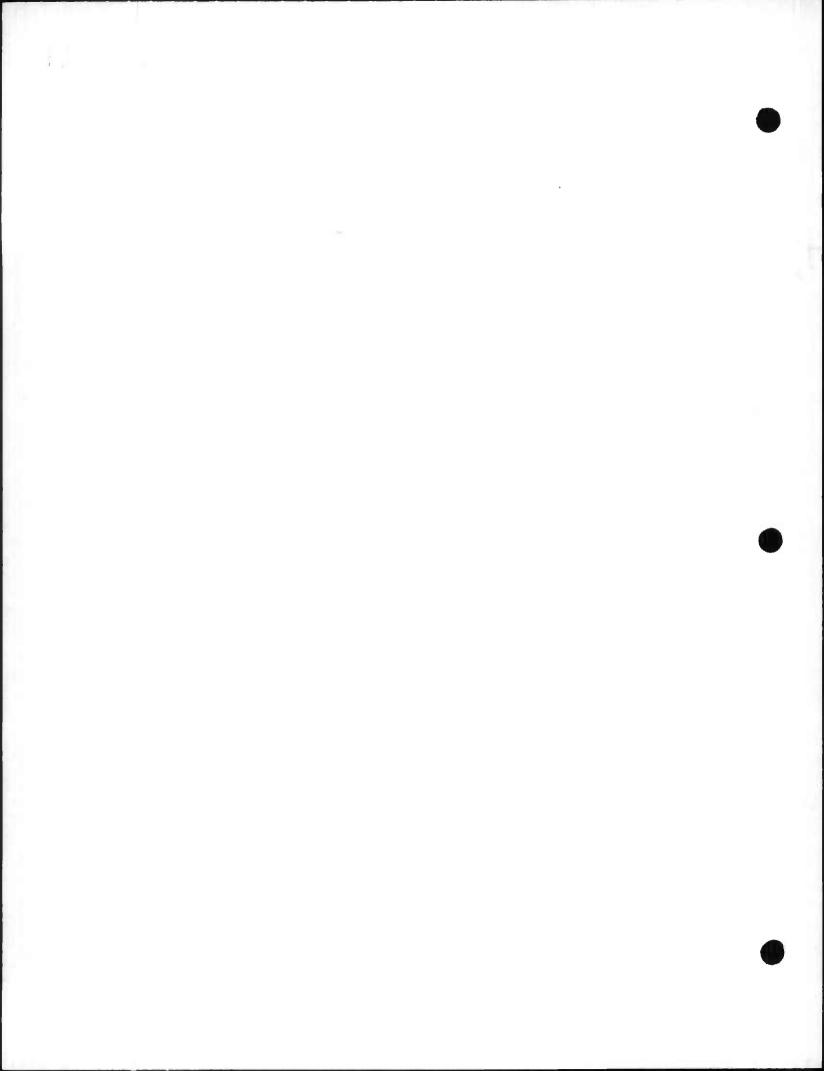
296. SIGNATURE AND TITLE OF CERTIFIER

Savo

31. DATE FILED (Month, Day, Year)

0

32. REGISTRAR'S SIGNATURE



1 - FOR STATE REGISTRAR	STATE OF MARYI	AND / DEPARTM CERTIFICA			MENTAL HYGIEN REG. NO.	E			
1. DECEDENT'S NAME (First, M FRANCIS			Notti	ngham	2. DATE OF DEATH NOV. 4	995 Y	3. TIME OF DEATH 3:15 A _M		
4. SOCIAL SECURITY NUMBER 225-66-991			UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH JAN . 3, 1619	46	BIRTHPLACE (State or Foreign VIRGINIA		
MEMORIAL RESIDENCE OF DECE	HOSPITAL	9b.	EAST(N LOCATION OF DE	АТН	9c. COUNTY OF DEATH TALBOT			
	Ob. COUNTY TALBOT	100	NO OR LOCAT	ION		10d. INSIDE LIMITS? 1 X YES 2			
100. STREET AND NUMBER 107 WEST O	AK AVENUE		10f.	21601		10g. CITIZEN	OF WHAT COUNTRY?		
11. MARITAL STATUS 1 Never Married 2 X M 3 Widowed 4 Divorce	I IF YES, GIVE WAR OR I	2 XNO	If yes, spe	ENDENT OF HISPAN Hocity Cuben, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yea n, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Space		
(Specify only h	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AGRICULTURE D MARKETING REPRESENT.								
17. FATHER'S NAME (First, Midde FRANCIS IR	NOTTINGHA	AM			ME (First, Middle, Maiden GOFFIGO				
199. INFORMANT'S NAME (Type CAROL S. N		195. MAILING ADD 107 WE			EASTON,				
20a. METHOD OF DISPOSITION 1 Burlel 2 Commatton 4 Donation 5 Other (S	pecify)	SALISBURY	CREM	ATORY	11-5 SA		or Town, State RY, MD.		
21. SIGNATURE OF FUNERAL	51 In Harrison	2 (E(2		S. HARR	NEWNA		ERAL HOME TON, MD. 216		
	peses, or complications that cause int fellure. List only one ceuee on a. hyp A to	eech line.		de of dying, auc		iratory erreet	Approximate interval Between Oneet and Death		
Sequentielly list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST	ete G Chrur	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF):	hol a	abusa	,		months		
	conditione contributing to death				PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIDR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO		
DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?	MEDICAL HOSPITAL:	26. PLACE OF DEATH (Check only one)	UNCERTAIL	N 🗆 📗				
1 TYES 2 TO	1 Inpatient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year)	tpetient 3 DOA 4 [F 28c. INJ		6 Other (Specify) 26d. DESCRIBE HOW	INJURY OCCUR	ED		
3 Suicide 6 C	vestigation	TY — At home, ferm, stree	M 1 🗆 1	rES 2 NO	281. LOCATION (Street City or Town, State	and Number or	Rural Route Number,		
(Orlock Orly)	FYING PHYSICIAN: To the best of my kno						euse(e) end menner ee stated.		
29b. SIGNATURE AND TITLE C	My an	m.D.		29c. LICENSE NU	MBER	29d. DATE S	IGNEO (Month, Dey, Year)		
	SANCHEZ, M.D.			AVE. E	ASTON, MI	216	01		
31. DATE FILEO (Month, Day, Ye	/ / / /								

DIVISION OF VITAL RECORDS, P.O. BOX 68760

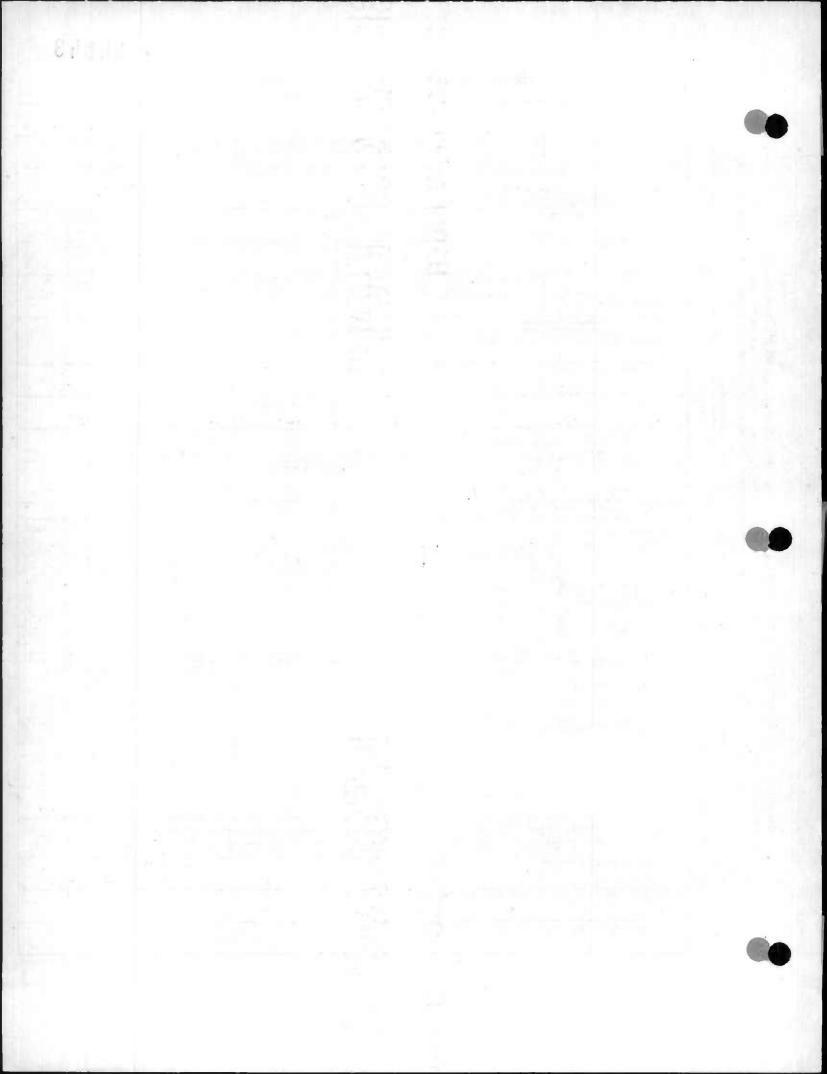
BALTIMORE, INC.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wirt ours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTION. After this certificate has been signed by the attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	STATE OF MA		PARTMENT OF		MENTAL HYGIEI		
1. DECEDENT'S NAME (First, Middle, Last) ZOLA A. NELSON					2. DATE OF DEATH MONTH NOV. 4,	1995 °	3. TIME OF DEATH 2:35 A M
4. SOCIAL SECURITY NUMBER 212-36-1997	1 🗆 M 2 💢 F	AGE (In yrs. lest birtho	S. MONTHS DAY	B HOURS MM.	7. DATE OF BIRTH (Month, Day, Year) Aug 19, 1	1931	BIRTHPLACE (State or Foreign Country)
99. FACILITY NAME (If not institution, give CUMBERLAND NURS RESIDENCE OF DECEDENT		2		N OR LOCATION OF	DEATH	9c. COUNTY	OF DEATH EGAINY
10a. STATE 10b. COUNT	egany	Dec. 1	cury, town on Lo			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
100. STREET AND NUMBER 11101 Forrest As				101. ZIP CODE 21502		N OF WHAT COUNTRY?	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 IF YES, GIVE WAF	YES 2 NO	If you	DECENDENT OF HISPA	ANIC ORIGIN? (Specify Yocan, Puerto Rican, atc.)	es or No 14	S. RACE — American Indian, Black, Whita, atc. Specify: White
15. OECEDENT'S EOI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	(Give kind life. Do NO	NT'S USUAL OCCUP of of work done during OT use retired.)	ATION most of working	16b. KIND OF BI		
17. FATHER'S NAME (First, Middle, Last) Frank Nelson		2100100			JAME (First, Middle, Maide YS TIMN		
19a. INFORMANT'S NAME (Type/Print) Dale F. Wright 20a. METHOD OF DISPOSITION		1110	1 Forres	t Avenue,	NE; Cumbe	erland,	MD 21502
1 Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI		cemetery, crematory	urg Crem		11/04 Sr	nithsbu	y or Town, State arg, MD
23. PART . Enter the diseases, or	Scarp	ell:	Cum	berland.	neral Home MD 21502		
ahock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Congest	on each line.			on as cardiac of 160	prictory arrea	Approximate interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	R AS A CONSEQUENC					
PART II. Other algnificent condition	na contributing to de	eeth but not resulti	ing in the under	ying cause given i		IN AUTOPSY DRMED? 2 M NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	3. PLACE OF DEATH (C	Check only one)		
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1 Inpatient 2 E	ER/Outpatient 3 DC JURY Year) 28b.	TIME OF 28c	Home 5 Residence INJURY AT WORK? YES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCU	RED
2 Accident investigation 3 Suicide 6 Could not be 4 Homicide datermined	28a. PLACE OF building, at	NJURY — At home, fac. (Specify)	rm, street, fectory,	office	281. LOCATION (Stree City or Town, State	t and Number or re)	Rural Route Number,
anal					ue to the cause(s) and m		cause(a) and manner ea stated.
29b. SIGNATURE AND TITLE OF CERTIFIE	J. Jaston	~	Just	29c. LICENSE N			SIGNED (Month, Day, Year)
Dr. Sunil K. Gup	V			rland, MD	21502		
31. DATE FILED (Month, Day, Year)	Jahra d'Awards	s signature on homball	55				





	REGISTRAR		CERTIF	ICATE C	F DEATH	REG	i. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	27.7	,			2. DATE OF DEA	ATH DAY	YEAR	3. TIME OF DEATH
	Neva M	Nilar	na			Oct.	30 19		2:45 p
	212-54-=8331		in yrs. last birthday) 97 YRS.	MONTHS DAY		7. DATE OF BIRT (Month, Day, Y Feb. 11,	bar)	Country	PLACE (State or Foreign) nna.
OR	99. FACILITY NAME (If not institution, give stree Egle Nursing Home	et end number)		Lonaco	on ing	EATH		egan	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CIT	TY, TOWN OR LO					10d. INSIDE CITY LIMITS?
ERAL D	Maryland Allega			y Cur	iberland 101. ZIP CODE	200	10g. CITI		1 X YES 2 NO
FUNE		2. WAS DECEDENT EVER IN FORCES? 1 YES			21502 DECENDENT OF HISPA			USA 14. RACE	- American Indian, White, etc.
ВУ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			, specify Cuben, Mexico YES 2 X NO Specif		(C.)		White
ETED	15. DECEDENT'S EDUCA' (Specify only highest grade co		16a. DECEDENT'S (Give kind of life. Do NOT u	work done during	ATION most of working		OF BUSINESS/IND	USTRY	
COMPL	9 17. FATHER'S NAME (First, Middle, Last)		Homem	aker	16 MOTHER'S N	Own	Home		
BE C	Frederick W. Grow	wden			Virgin	ia (Will	lison)		
TO E	190. INFORMANT'S NAME (Type/Print) Francis W. Niland	đ			et and Number or Rural Shallott		or Town, State, Zip 28470	Code)	
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remove	al from State com	PLACE AND DATE	ther niecel			Oc. LOCATION —		
i i i	4 Donation 8 Other (Specify)		Herest	22. NAM	Park 11, E AND ADDRESS OF FA	Kight	Funera	al Ho	me
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE O	NF):	teriose	clerosis			9 year
MEDICAL	0-1-1	^ ^	ut not resulting		ying ceuse given in	P	AS AN AUTOPSY ERFORMED? (ES 2) NO		WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO
SICIAN:		HOSPITAL:		OTHER:	B. PLACE OF DEATH (C)				
РНУ	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. Til	AE OF 28c	INJURY AT WORK? YES 2 NO		(y) HOW INJURY OCC	CURED	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,			281. LOCATION (City or Town,	Street and Number State)	or Rural Ro	oute Number,
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER:						end menner as state		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	v. Res	a.n		29c. LICENSE NU	MBER 504	29d. DAT	e SIGNED	(Month, Day, Year)
ТО	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED OF DE	ATH (ITEM 27) (Type	e, Print)	un m	D			
	NOV 03 1995	Julia d'Austra	-Randoll	0	1				

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

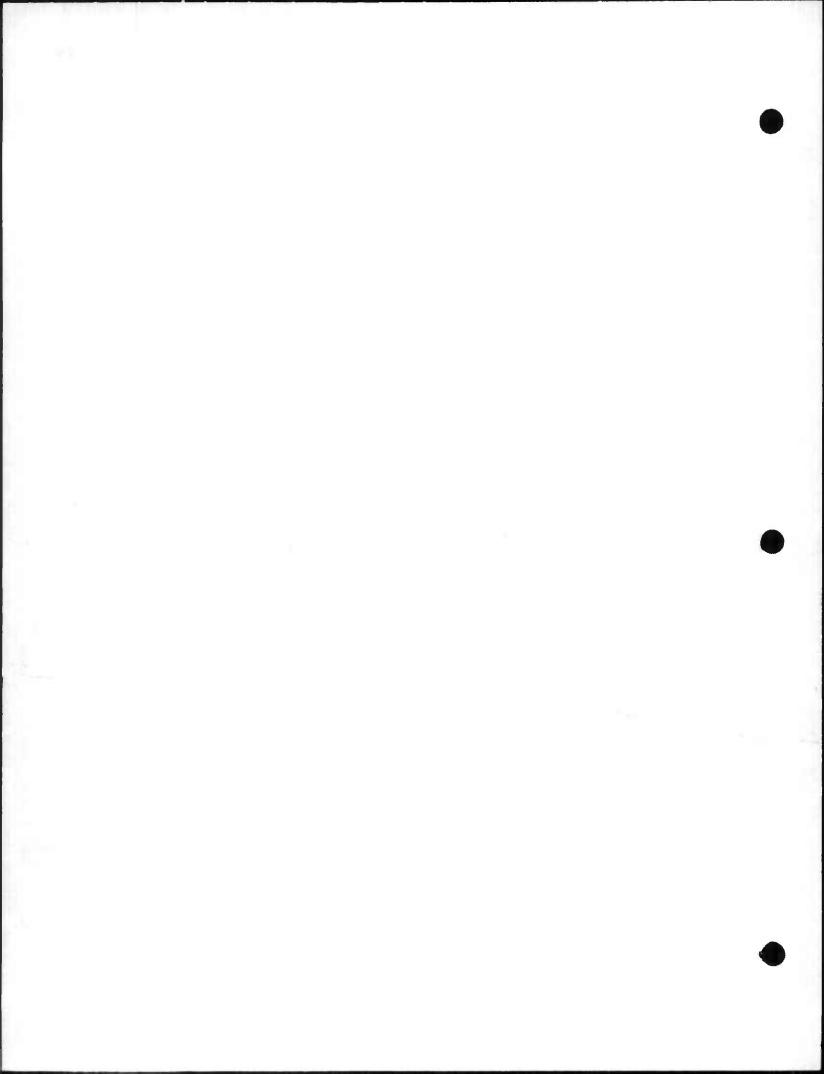
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within set hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN	Ε			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		Т	3. TIME OF DEATH	
	RUTH VIRGIN	IA NELSON				Nov. 2		EAR	11:05 a M	
		5. SEX 6. AGE (II		UNDER I YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	0.	BIRTHE	PLACE (State or Foreign	
	233-66-7332	1 □ M 2 🔀 F 81	YRS.	ONTHS DAYS	HOURS MIN.	Oct.13 19	14	Country	W.Va	
	9a. FACILITY NAME (If not institution, give stre	et and number)	9(b. CITY, TOWN C	R LOCATION OF D		9c. COUNTY	OF DE	ATH	
OR	Sacred Heart Hospital Cumberland Allegany									
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		I so orry -	OWN OR LOCAT						
DIRECTOR	W.Va Miner	al	Keyse		ION			1	10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER		1 2		. ZIP CODE				1 🖾 YES 2 🗌 NO	
RA	Mamla	CL		1000	26726		USA		HAT COUNTRY?	
FUNERAL	Maple 11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED			NIC ORIGIN? (Specify Yes			- American Indian,	
	1 Never Married 2 Merried	FORCES? 1 YES		it yes, spe	2 NO Speci	an, Puerto Rican, etc.)	0, 100	Black,	White, etc.	
ВУ	3 🔀 Widowed 4 🗌 Divorced				I Z IIV Speci	ry.	W	Specify		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	16a. DECEDENT'S US	UAL OCCUPATIO	ON st of working	16b. KIND OF BUS	SINESS/INDUS	TRY		
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re Housewil.			Domes	stic			
MP	10		HOUSEWI.	re						
	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden : tty Cross	Surname)			
BE	Willis Cross 190. INFORMANT'S NAME (Type/Print)									
2			196. MAJLING AD	Maple Maple	nd Number or Rural	Route Number, City or Town	7. State Zio Co	(de)		
	Robert R. Nelson	1 201	PLACE AND DATE OF D	-						
	1∑ Buriel 2 ☐ Cremation 3 ☐ Remov. 4 ☐ Donation 5 ☐ Other (Specify)		OF CEMET				cation — chy Elk Gai			
	21. SIGNATURE OF FUNERAL SERVICE LICE			-	D ADDRESS OF FA	VCILITY				
	► (//	R A		David	A Burdo	ck Funeral	Home	- 20		
	22 PARTA Enter the discourse	Modeck				itzmiller,M				
	23. PART I. Enter the diseeses, Dr coo shock, or heart fellure. Lis	at only one cause on ea	the death. Do not ch line.	enter the mod	de of dying, suc	ch as cardlec or respli	ratory errest	t,	Approximate interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	1.		lan	0 -				Onset and Death	
ŀ	resulting in death)	DUE TO JOR AS A	CONSEQUENCE OF:	50						
,		של אל אל אל אל אל אל אל אל אל אל אל אל אל	SONSEGUE GF).							
Ö	Sequentially list conditions, if any, leeding to immediate	DUE TO JOR AS A	CONSEQUENCE OF):							
S	cause. Enter UNDERLYING									
틸	CAUSE (Disease or Injury thet Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	resulting in death) LAST									
AL C	PART II. Other significent conditions	contributing to deeth bu	t not resulting in t	he underlying	cause given in	Part I. 24s, WAS AN	ALITOPEV	245 1	WERE AUTOPSY FINDINGS	
CA		•			dado given in	PERFORI	MEO?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC						1 🗆 YES 2	□-40	۱ ۹	OF DEATH?	
2	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	Пиоп	UNCERTAI	NO		1	YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		B. PLACE OF DEATH (ONCERIAI	N L I				
Sic	EXAMINER?	IOSPITAL: Inpetient 2 ER/Outpet		THER:	5 Besidence	6 Other (Specify)				
٤١	27. MANNER OF DEATH	26e. DATE OF INJURY	26b. TIME O	F 26c. INJU	JRY AT	28d. DESCRIBE HOW IN	JURY OCCUR	ED		
ВУБ	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY		ES 2 NO				1	
	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, etc. (Specif	At home, lerm, stree	ol, factory, office		281. LOCATION (Street as City or Town, State)	nd Number or F	Rural Ro	ute Number,	
	4 Homicide determined					Only or lown, steller				
7	29e. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowle	dge, death occurred at	t the time, date	end place, end due	to the cause(e) end meni	ner as stated.			
COMPLETED		On the basis of examination						euse(e) (end menner as stated.	
	29b. SIGNATURE AND THE OF CERTIFIER				AQC. LICENSE NUI	MBER	29d. DATE SI	GNEÓ (/	Month, Day, Year)	
3 BE		line 1	MP		1103	459	D 1/	1	Slar	
일	36. MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Prin	nt)				/ +	1/47	
	IL-FINNA	MIT	902	- 5:	ETON	DR		14	ab MI	
	31. DATE FILED (Month, Day, Ybar) NOV 0 6 1995	32. REGISTRAR'S SIGNAT	URE	•					1.6	
8	NOV 0 6 1995	Jama commence	- Mardana							

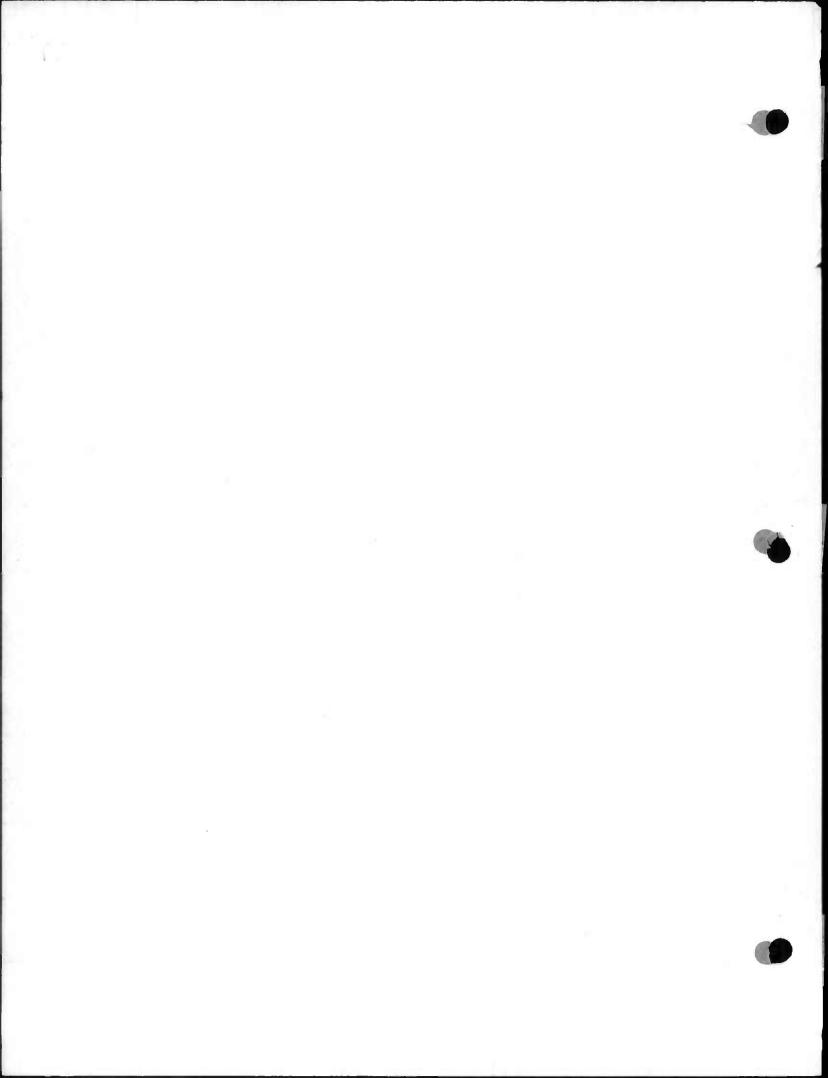


DIVISION OF VITAL RECORDS, P.O. BOX 68769 Se BALTIMORE, MARYLAND 21215-0020

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

		REGISTRAR			CERTIF	ICATE (OF DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE O				3. TIME OF DEATH
		Stella Louise	Oliveri					Octo	oer 3		95	0815 M
		4. SOCIAL SECURITY NUMBER	5. SEX 6. /	AGE (In yr	s. last birthday)	IF UNDER 1 YE	EAR IF UNDER 24 HRS.	7. DATE OF	BIRTH		6. BIRTHP	LACE (State or Foreign
_		219 - 34 - 0238	1 □ M 2 ☑ F	8	31 YRS.	MONTHS DA	YS HOURS MIN.	ebruar	Day, Year)	191/	Country)	ryland
3 should		9e. FACILITY NAME (If not institution, give a	treet end number)			96. CITY, TO	WN OR LOCATION OF D		. y 14		TY OF DE	
	8	Union Hospital o	f Cecil Cou	intv			E1k	ton		Ce	cil	
1, 2,	5	RESIDENCE OF DECEDENT							.TACON OCCIT			
rages -	DIRECTO	10a. STATE 10b. COUNT	r		10c. CIT	Y, TOWN OR L	OCATION					10d. INSIDE CITY LIMITS?
Ę.		Maryland	Cecil				Charlest	own				1 YES 2 NO
	ĭ.	10e. STREET AND NUMBER					10f. ZIP CODE			10g. CITIZ	EN OF W	AT COUNTRY?
benderdanskt permit,	ij	807 Bladen Street					21914			Un	ited	States
	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV FORCES? 1 1			13. WAS	DECENDENT OF HISPA s, specify Cuban, Mexic	NIC ORIGIN?	(Specify Yes	or No-	14. RACE -	- American Indian, White, atc.
	ΒYΙ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR				YES 2 NO Speci		an, etc.)	- 4	Specify	W 800 A
	ED E											
	ETE	15. DECEDENT'S EDU (Specify only highest grade		164	Give kind of v	vork done durin	PATION og most of working	16b. K	IND OF BUS	SINESS/INDI	USTRY	
	빌	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ι,	Ille. Do NOT us	,						
once.	COMPL	6		1	Homemak	er				n Hom	e	
at on		17. FATHER'S NAME (First, Middle, Last)	1				16. MOTHER'S NA			- 111-		
	8	Michael F. Nastic	CK				Joseph					
notified	2						reet end Number or Rural				Code)	
9		June M. Oliveri-S	spangler				Street, Ch				21914	
must		1 ☐ Buriel 2 1 Cremation 3 ☐ Rem	oval from State	cemetery	ACE AND DATE O	her plece)		OATE		CATION — C	-	
E E		4 Donation 5 Other (Specify)	EUDEE O	R.	A. Fer		ematory	11/3		t Che	ester	, Pennsylv.
i. examiner	- 7	11/1/1/1/	ENSEE			Croi	E AND ADDRESS OF FA	I Home	2			
exa exa		" What 1.	retur	4		127	South Main	n Stre	et, N	North	East	, MD 21901
or removal. medical examiner must be notified at once.		23. PART i. Enter the diseases, or	complications that car	used the	e deeth. Do n							Approximate
5 6		ahock, or heart feilure. IMMEDIATE CAUSE (Finel	List only one cause of	on eech	line.							interval Between Onset and Death
to burial, cremation, or matic event, the r		disesse or condition	100		MVA	1000	in I INI	LARC:	7701	,		imperinte
remt,		reaulting in death)	DUE TO (OR	AS A COI	NSEQUENCE OF	F):	2,07	7.70-7				THREVIATE
ic e	2		CA	20								į l
ry, or other traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A COL	NSEQUENCE OF	7):						
로	B	cause. Enter UNDERLYING										
or other	Ĕ	CAUSE (Disease or injury that initiated events	OUE TO (OR	AS A CO	NSEQUENCE OF	7):						
6	E	resulting in death) LAST	d									
njury, o	O	PADT II Other elgoliticant condition										
any Injury,	CAL	PART ii. Other significant condition	s contributing to dee	n put n	iot resulting i	n the under	iying ceuse given in	Part i. 2	4a. WAS AN PERFOR		1	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
s an	<u>a</u>							[•	YES 2	⊠ NO		COMPLETION OF CAUSE OF GEATH?
shows	ME										1	YES 2 NO
23 \$	ÿ	DID TOBACCO USE CONT	RIBUTE TO CAUSI					N 🔲				
1, or item 23 shows an	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. F	PLACE OF OEAT		one)					
0r 10	YSI	1 TYES 2 NO	1 ☑ Inpatient 2 □ ER/	Oulpatier	nt 3 🗆 DOA	OTHER:	Home 5 - Residence	6 Other (Specify)			
ed,	PHY	27. MANNER OF DEATH	28e. DATE OF INJL (Month, Day, Ye	JRY ear)	28b. TIM	E OF 28c	INJURY AT WORK?	28d. DESCI	RIBE HOW I	NJURY OCC	URED	
s marked,	BY	1 Netural 5 Pending 2 Accident Investigation					YES 2 NO					
		3 Suicide 6 Could not be	28e. PLACE OF INJ building, etc.	JURY — A (Specify)	At home, lerm, s	treet, fectory,	office		ION (Street a Town, State)	nd Number o	or Rural Ro	ute Number,
1 28		4 Homicide determined						Only on	iowii, Gialey			
item 28 is	COMPLET	290. CERTIFIER (Check only 1) CERTIFYING PHYSI	CIAN: To the best of my is	nowledge	e, death occurre	d at the time.	date end place, and due	to the cause	(s) end men	ner as state	d.	
1 == 1	M	one) 2 MEDICAL EXAMINE										end menner es stated.
TAN		290. SIGNATURE AND TITLE OF CERTIFIES					29c. LICENSE NUI		1			
IMPORTANT: 1	8	1.10	7/)								Month, Day, Year)
=	2	30. NAME AND ADDRESS OF PERSON WH	O COMPNETEO CAUSE O	F OEATH	(ITEM 27) /Tona	Print)	D 3239	15		1	1-01	<u>-95</u>
		3 Mauldin Avenue					- Dr. Tho	mas Fi	ໃກນວາ	n		
		31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S			901	DI. IIIO	mas Fl	inucal			
- {		NOV 0 2 199	5 Juli As.	ecline	Roul-11							1
- 1		110 0 0 0 133	Juna will	well M.	~ CMPTA/ILA							

	FOR 1 - STATE REGISTRAR	STATE OF MARY				EALTH AND	MENTAI	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)			T TOX		DEATH	2. DATE	OF DEATH			3. TIME OF DEATH
,	Philip Jos	eph Prima	aldi				OCT	ber	30,9	SEAR 5	0450 A M
į	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. lest birthda	iy) IF UNDE	R 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTH	IPLACE (State or Foreign
ì	195-05-0582	X□ M 2 □ F	86 YRS	MONTHS	DAYS	HOURS MIN.		Day, Year)	08 1	Count	ware
	9e. FACILITY NAME (If not institution, give s	street and number)		9b. CIT	Y, TOWN C	R LOCATION OF D			9c. COUN		
מטוספעוט	Union Hospita	1		El	ktor	1			Cec	il	
ונ	10e. STATE 10b. COUNT	Υ	10c. (CITY, TOWN	OR LOCAT	ION					10d. INSIDE CITY
	Delaware New	Castle		Tow	nser	nd					LIMITS? 1 YES 2X NO
LONGRAL	P.O. box 66					2 7 3 4				EN OF V	WHAT COUNTRY?
	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED			ENDENT OF HISPAI	NIC OBIGIN	2 (Specify Ver			E — American Indien,
	1 Never Merried 2 Merried	FORCES? TYPE	2 NO		If yes, spe	2 NO Specif	n, Puerto i		G 110-		k, White, etc.
3	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDEN' (Give kind	T'S USUAL (OCCUPATIO	ON st of working	16b.	KIND OF BU	SINESS/INDU	JSTRY	-
COMPLE	Elementery/Secondary (0-12)	College (1-4 or 5+)			•		1,	lhd a 1	D	3 d	_
4	12		Maste	r we	raer			Ship 1		ıın	9
	17. FATHER'S NAME (First, Middle, Last)	4				18. MOTHER'S NA					
	Louis Primald 190. INFORMANT'S NAME (Type/Print)	1						sett.			
2		2 m G	1			nd Number or Rural					0712
	Phillip Willia 200. METHOD OF DISPOSITION		Db. PLACE AND DA			ngston	RU.,		CATION — C	_	
	1 Suriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		emetery, cremetory	or other place	9)						ton, De
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSE	racela		NAME AN	cial Pa	CILITY	•			· · · · · · · · · · · · · · · · · · ·
	Pata	THER		1-		ELS &HU					
-	or name i feature in	17000	7			broad					
	23. PART i. Entar tha diseasea, or ahock, or heart fallure.	List only one ceuse on	ed the daath. D eech lina.	o not ente	er the mo	da of dylng, suc	ch as card	llac or rasp	Iratory erre	est,	Approximata Intarval Between
ì	iMMEDIATE CAUSE (Final disease or condition	M	1 1			0	P		· ·		Onset and Death
	resulting in daeth)	Massine	(eu	era	190	cufai	LE	KIOL	ent		
	/	U. OF AS	Tam A	E OF):							
HILICATION	Sequantielly list conditions,	b. TO (OR AS	A CONSEQUENCE	E OF							
3	if eny, leading to immediata cause. Entar UNDERLYING	0		1000							
Í	CAUSE (Diseese or Injury that Initieted avents	DUE TO (OR AS	A CONSEQUENCE	E OF):							
2	resulting in death) LAST	d.									
3	OADT il Other elepificant conditio	no contribution to doubt	h							T	1
3	PART II. Other significant condition	To death	but not reaultin	ng in the t	inderiyin	g cause given in	Part I.	24a. WAS AN PERFO		248	WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO COMPLETION OF CAUSE
	(MACOUSTA!	1//						1 TYES	NO		OF DEATH?
	DID TOBACCO USE	CONTRIBUTE TO	CALISE C	E DEA	TLI V	ES NO					1 TYES 2 NO
PATSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL	TOM KIBOLE 10	CAUSE	I DEA			-	1		\perp	
2	EXAMINER?	HOSPITAL:		OTHE	ER:	ACE OF DEATH (C/	,				
اخ	27. MANNER OF DEATH	28e. DATE OF INJUR		TIME OF	28c, INJ	ury AT		CRIBE HOW	INJURY OCC	LIBED	
- 88	1 Natural 5 Pending	(Month, Day, Year		INJURY	WO	YES 2 NO		,01100		01100	
0											
	4 Homicide 6 Could not be determined	building, etc. (S	pecify)				City	or Town, State)		
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my kno	windon don't a	the beauty	time de	and place and d	a to the	social and	nnar	.,	
MIL	one) —	ER: On the besis of examinat									e) end menner ee steled.
	29b. SIGNATURE AND TITLE OF CERTIFIE				.,			, , , , , , , , , , , , , , , , , , ,	_		
	BULL OF CENTIFIE	7 /	4.			29c. LICENSE NU	MBEH	,	29d. DATE	SIGNE	(Month, Day, Yeer)
2	80. NAME AND ADDRESS OF PERSON W	HO COMPLETED CALIFFE OF	DEATH (ITEM 27)	Non Print		LOWY	10		/	0.	7/ 7/7
	V	rey, Suite			n me	edical	Buil	lding	,Elk	ton	,Md.
	31. NOV 01 1995	12 REGISTRAN'S SH									
1	MON OT 1939	Hely attended to	whall								



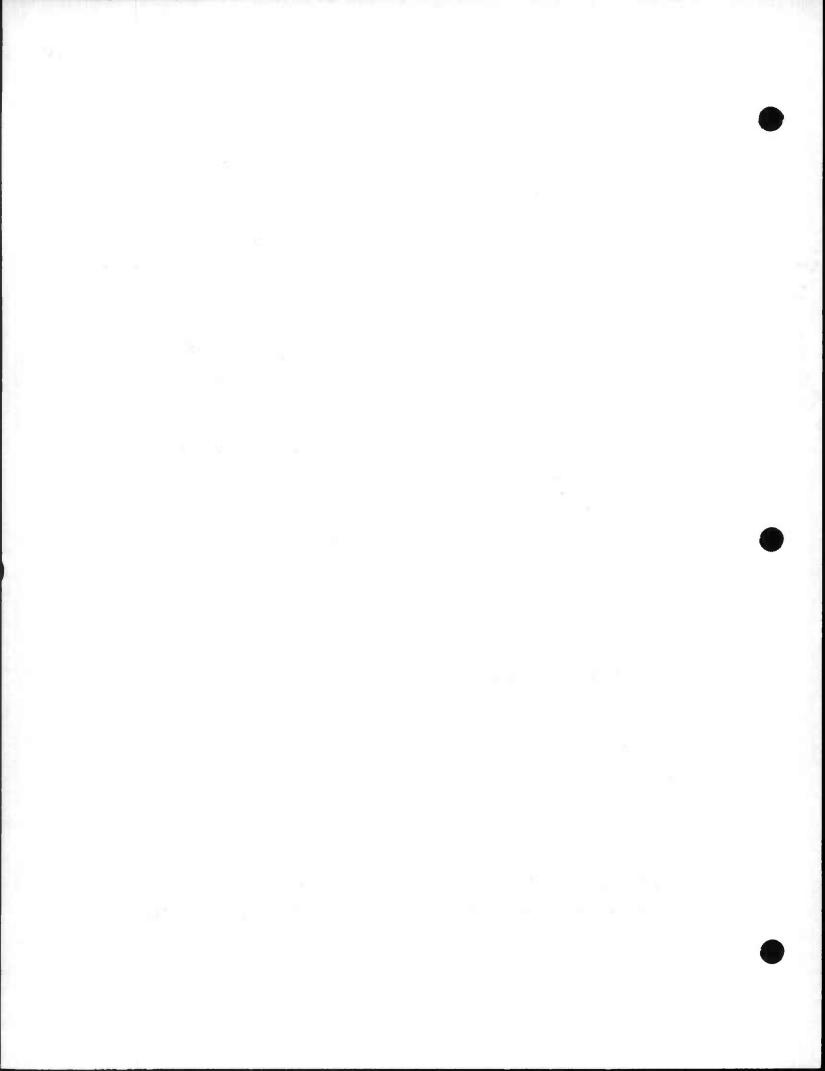
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL, DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

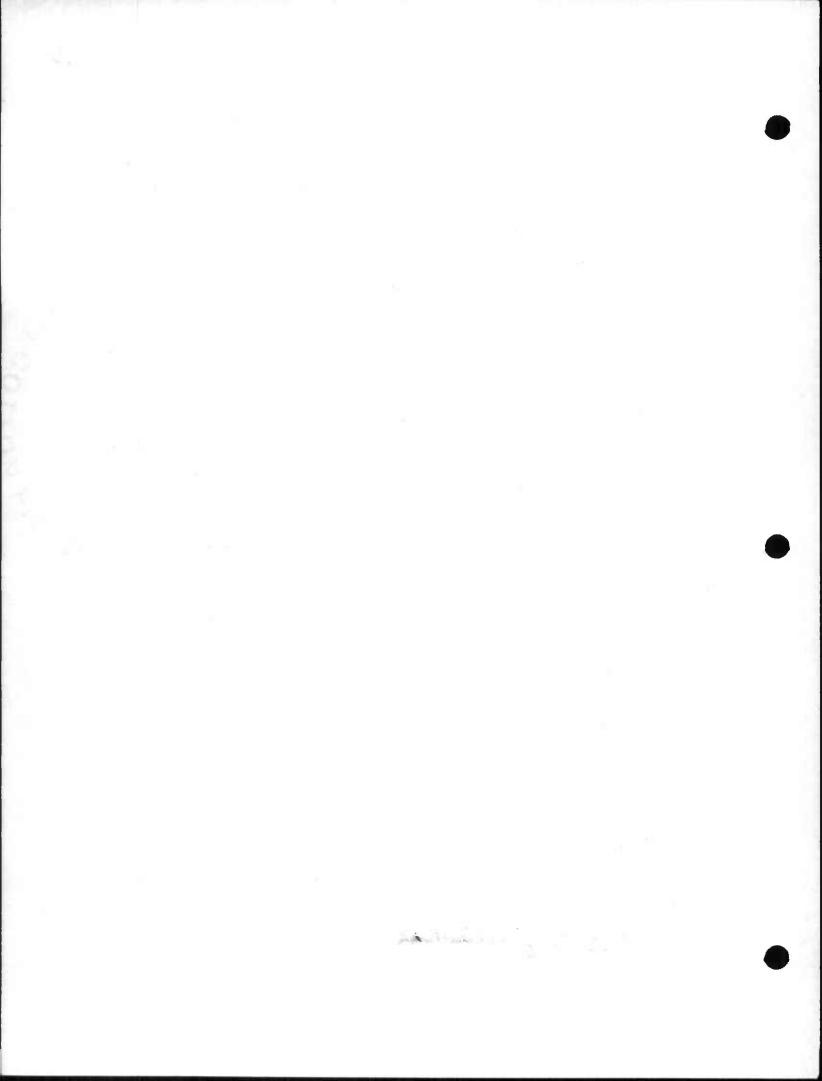
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 12 hours after death with the State Dept. of Health and Merical Hyghere prior to removal the medical examines must be marked, or them 23 shows any injury to other transmatte examines marked.

	1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	TMENT OF HI	EALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	PATRICIA ANN	POTT				NOVEMBER	3,1995	1:15 P M	
	4. SOCIAL SECURITY NUMBER 579-48-7791 90. FACILITY NAME (If not institution, give st	1 □ M 2 X F 59	rs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) FEB. 17.1	936 NE	HRTHPLACE (State or Foreign country) W JERSEY	
DIRECTOR	3008 FREEDOM COUR			9b. CITY, TOWN OF		ЕАТН	9c. COUNTY OF DEATH CHARLES		
H	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCATE	ON			10d. INSIDE CITY	
	MARYLAND CHA 10e. STREET AND NUMBER	RLES	WA	LDORF 10f.	ZIP CODE		10g. CITIZEN	1 ☐ YES 2 💢 NO OF WHAT COUNTRY?	
FUNERAL	3008 FREEDOM COUR	T NORTH			20603		U.S	-A-	
	11. MARITAL STATUS 1 Never Married 2 X Merried	12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2	2 V NO	13. WAS DECE	NOENT OF HISPA	NIC ORIGIN? (Specify Yer	or No- 14. 1	RACE — American Indian, Black, White, etc.	
à	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	SA	1 TYES	2 NO Specif	у:		Specify: WHITE	
	15. DECEDENT'S EDUC (Specify only highest grade	CATION 16	e. DECEDENT'S	USUAL OCCUPATION	N	16b. KIND OF BU	SINESS/INDUSTI		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us						
ĕ de	12	M	ANAGER/	BOOKEEPE		HOTE			
	17. FATHER'S NAME (First, Middle, Last) ROBERT SIEMAN					ME (First, Middle, Maiden			
BE	19a. INFORMANT'S NAME (Type/Print)		19h MAILING	ADDRESS /Street on	GERTRUI	DE MACDOI Route Number, City or Tow			
10	EDWIN LOUIS P	ОТТ						LAND 20603	
	20e. METHOD OF DISPOSITION 1 V Buriel 2 Cremetion 3 Remo 4 Donation 5 Dotter (Specify)	weel form Clate		F DISPOSITION (Nan			CATION — City of		
Ē	21. SIGNATURE OF CINERAL SORVICE LICE		NI IN ME	MORIAL G	ARUENS ADDRESS OF FA		_DORF,	MARYLAND	
CYG	BENJAMIN M. M	ATTHEWS M-006	58	THE HU	NTT FUN	ERAL HOME, WALDORE, M	INC	20004	
	23. PART I. Enter the diseases, or co	omplications that caused th	a death. Do n	ot enter the mod	le of dying, suc	h as cerdisc or reepi	ratory arrest,	Approximate	
	immediate cause (Final	List only one couse on each	line.					Interval Between Onset and Death	
	disease or condition resulting in death)	LART	70a/ C	ANCE	C			14 mon 7 hs	
2	The state of the s	DUE TO (OR AS A GO	NSEQUENCE OF):					
NO	Sequentially list conditions,	DUE TO (OR AS A CO	INSECUENCE OF) .					
AT	If any, leading to immediate cause. Enter UNDERLYING	50E 10 (011 N3 X CO	MSECULINCE OF	J.					
E E	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	INSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST	J,							
	PART II. Other algnificant conditions	contributing to deeth but i	not resulting is	n the underiving	ceuse given in	Part I. 24s. WAS AN	ALITOPEY	24b. WERE AUTOPSY FINDINGS	
CAL	History of	BReast CA	NIER	. are arraorrying	oodse given in	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC	0					1 YES 2	XNO	OF DEATH?	
2	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF I	DEATH YE	S \square NO \square	UNCERTAIL	<u>ч</u> П	- 1	1 TYES 2 XNO	
N N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.		H (Check only one)	OTTOERITAIN	, 0			
PHYSICIAN:	1 YES 2 X NO	HOSPITAL: 1 Inpatient 2 ER/Outpatie	nt 3 🗆 DOA	OTHER: 4 Nursing Home	5 X Residence	6 Other (Specify)			
P. H.	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME		RY AT	28d. DESCRIBE HOW II	JURY OCCURE	0	
B	1 Natural 5 Pending 2 Accident Investigation			M 1 TYE	S 2 NO				
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, at	treet, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Ru	ral Route Number,	
COMPLET	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSIC	IAN: To the best of my knowledg	e, death occurre	d at the time, date e	ind place, and due	to the cause(e) end men	ner se stated.		
No.		: Op the basis of examination as						se(e) and menner se stated.	
BE C	296. SIGNATURE AND TITLE OF CHATIFIER	1	-		29c. LICENSE NUI	IBER	29d. DATE SIG	NED (Month, Day, Year)	
TO B	Name VK	Her Ku			0203	55	D ///	6 195	
-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type,	Print)	RO	Muron	Med		
	31. DATE FILED (Month, Day, Year)	Las acceptances elements	RE Randall	7.701)	, 0, (11111111	(J)		
	NOV 0 7 1995	falla d'aucles	x hardall						



D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Realth and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE F	TO THE F	IMPORT

	1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	21L	Po	WELL		2. DATE OF DEATH DAY	9.1995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (Ir	yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign
	214-68-8638 9a. FACILITY NAME (If not institution, give stre-	et and number)	39 YRS.	9b. CITY, TOWN C	R LOCATION OF DE	DEC.3,19	55 WAS	SH., DC
DIRECTOR	7907 GREENLEAF				DOVER		_	GEORGE'S
일	10a. STATE 10b. COUNTY		10c. CIT	, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	MARYLAND PRINC	E GEORGE'S	S LA	NDOVER				XX YES 2 NO
FUNERAL	100. STREET AND NUMBER 7907 GREENLEAF	RD.		10f	20785		10g. CITIZEN OF USA	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 11. XNever Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DAY 9/19/74-1	2 INO MAR	If yes, sp	cify Cuben, Mexica	IIC ORIGIN? (Specify Yea n, Puerto Rican, atc.)	or No— 14. RAC Black Spec	E — American Indian, ck, White, etc.
	15. DECEDENT'S EDUCA	TION	15e. DECEDENT'S	USUAL OCCUPATION		18b. KIND OF BUS	INESS/INDUSTRY	
COMPLETED		College (1-4 or 5+)	life. Do NOT us		st or working	GOVER	NMENT	1 0
M M	llth		LABOR	ER		I (TOWN	OF CHEV	VERLY)
	17. FATHER'S NAME (First, Middle, Last) UNKNOWN					ME (First, Middle, Maiden S SARET ANN		N.
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or Town		
٩	BARBARA BOONE/		300			FORESTVI		
	15 Buriel 2 Cremetion 3 Remov	al from State 20b.	PLACE AND DATE OF A REPORT OF			DATE 200, LOC	CHELT	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE A A	.1		DADDRESS OF FA		AL HOM	T
	• Juawana	8.120C	KION			ER RD. L		
	23. PART I. Enter the dieesses, or co ehock, or heert failure. Li iMMEDIATE CAUSE (Finel diseese or condition resulting in deeth)	CARCINO!	ch line.	ESOPI				Approximete intervel Between Oneet end Death 2 nws to
CERTIFICATION	Sequentielly list conditions, if sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initisted evente resulting in deeth) LAST	DUE TO (OR AS A						
PHYSICIAN: MEDICAL (PART II. Other eignificent conditions CAC.HEXIA	contributing to deeth bu	ut not resulting	in the underlying	g ceuee given in	Part I. 24a. WAS AN PERFOR 1 YES 2	MED?	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
N N	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YE	S NO [UNCERTAI	N 🗆		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA	OTHER.				
YSI	1 X YES 2 NO	1 - Inpetient 2 - ER/Outpe		4 - Nursing Hom		8 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	URY AT PRK? YES 2 NO	28d. DEŞCRIBE HOW IN	NJURY OCCURED	
	3 Suicide S Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Speci	— At home, term,	strant, tectory, offic	•	281. LOCATION (Street a City or Town, State)	nd Number or Rure	Route Number,
COMPLETED	(Crieck Orny	IAN: To the best of my knowl : On the basis of examination						(e) end menner se stated.
BE	29b. SIGNATURS AND TITLE OF CERTIFIER				29c. LICENSE NU D 25 9		≥ OCT	29, 1995
은	30. NAME AND ADDRESS OF PERSON WHO J, BERGER MD 7	COMPLETED CAUSE OF DEA	20 WIS	Print) CONSIA	s Ave,	BeThesa		d 20814
	31. DATE FILED (Month, Day, Year) OCT 31 1995	32 AFGISTHAR'S SIGNA	rhyht					

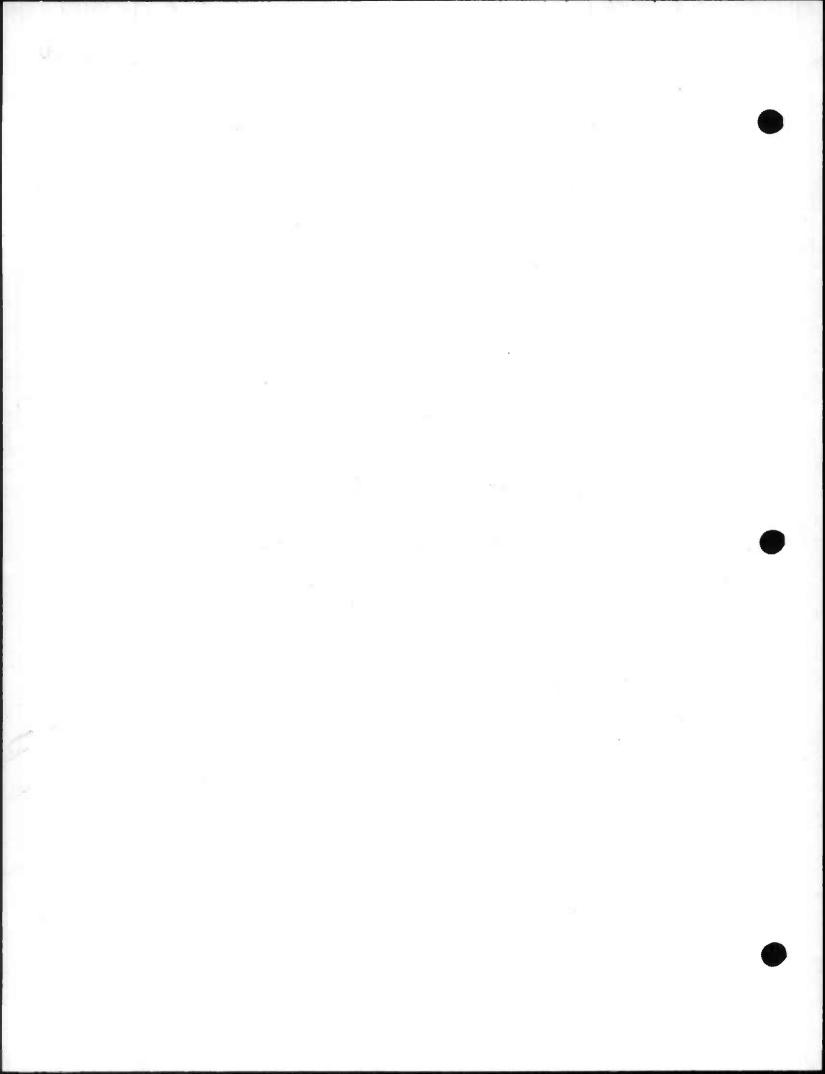


1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1. DECEDENT'S NAME (First, Middle, Last) LAURA 4. SOCIAL SECURITY NUMBER 216-12-7174	The second secon		NDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Morgh, Day, Year) Feb. 26,	31,19	BIRTHPLAC	IME OF DEATH 1: 18 € CE (State or Foreign
2, 3 should	ECTOR	9s. FACILITY NAME (If not institution, give st Harford Memorial RESIDENCE OF DECEDENT	reet and number)			or location of de vre de Gr	НТА	9c. COUNTY	OF DEATH	yland ford
physician. burial-transit permit. Pages 1, 2,	BIG	Maryland 10b. county	Cecil	10c. CITY, TO		rt Deposi	t			INSIDE CITY LIMITS? YES 2 NO
ansit perr	FUNERAL	900 Craigtown Ro	ad		10f. ZIP CODE 2190			10g. CITIZEN	J.S.A	
	ΒY	11. MARITAL STATUS 1 Never Married 2/XX Married 3 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yes, sp	CENDENT OF HISPANI pecify Cuban, Mexican 3 2 NO Specify:		Black, White, atc.		merican Indian, Ha, atc.
the hospital or attending detached for use as the once.	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) Ten Years	College (1-4 or 5+)	16a. DECEDENT'S USUA (Give kind of work of life. Do NOT use retir Homema	lone during mo ed.)	ON ost of working	18b. KIND OF BU	Home	RY	
8 E &	BE COM	17. FATHER'S NAME (First, Middle, Last) ROCCO Di	Marco		18. MOTNER'S NAME (First, Middle, Malden Surname) Mary Rapposelli					
ay be retained by page 5 should be notified a	TO	Frank Rinaldi, Sr	900 Crai	gtown	Road, Po	oute Number, City or Tow rt Deposit	n, Stete, Zip Good t, Mary	n) land	21904	
Page 6 may if director, pa		20a. METHOD OF DISPOSITION 1.X Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from Stata cen	PLACE AND DATE OF DIS DIOOKVIEW	emeter	ry 11/	4/95 Ris	ing Sun		
funera the		21. SIGNATURE OF FUNERAL SERVICE LICI	. Patters	OK. SV.	Lee A	ND ADDRESS OF FAC A. Patter yville, M	son & Son	Funera	1 Hor	ne
within 24 hours at pletely filled in by cremation, or remorement, the medical property.		23. PART i. Enter the diseases, or conshock, or heart failure. I. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ist only one couse on a	d the death. Do not en ach line.	nter tha mo	ode of dying, auch	as cardiac or reap			Approximate Interval Betwee Onset and Dear
th certificate be execu- tending physician and il Hygiene prior to bun or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	Sever	CONSEQUENCE OF):	ted	Sten	ieilur osis	e		
uires that the d signed by the Health and Me Ws any Injur	MEDICAL C	PART II. Other aignificant conditions Diabetes	contributing to death b	ut not resulting in the	Underlyin	g ceuse givan in F	Part I. 24a. WAS AN PERFOF	RMED?	COMF OF DI	E AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO
law rise be ept.	SICIAN:	DID TOBACCO USE CONTR		F DEATH YES [UNCERTAIN			-	
YSICIAN: The law rescribing the State Dept. of them 23 st	PHYSIC	EXAMINER? 1 YES 2 YNO 27. MANNER OF DEATH	HOSPITAL: 1 Inpetient 2 ER/Outp 28a. DATE OF INJURY		HER: Nursing Hom 28c, INJ	ne 5 Residence 8	Other (Specify)	William Occurs	-	
H H W	ВҰ	1 Netural 5 Pending 2 Accident investigation	(Month, Day, Year)	INJURY At home, farm, street,	W 1 🗆	PRK? YES 2 NO				
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State Ditem 28 is marked, or item	ETED	3 Suicide 8 Could not be determined	building, atc. (Spec	eny)			281. LOCATION (Street a City or Town, State)		ural Floute N	lumber,
= 28 F	COMPLE		GAN: To the best of my know						use(s) and	manner as stated.
TO THE HOSPI TO THE FUNER De filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	MD			D 316		29d. DATE SIG	NED (Mont	n, Day, Year)
		30. NAME AND ADDRESS OF PERSON WHO DISHARMA N		ATN (ITEM 27) (Type, Print)		- Have	le De	GRac	o Mj	0 21075
		31. DATE FILED (Month, Dey, Year) NOV 0 3 1995 Ju	32. REGISTRAR'S SIGN							
										DIMMI 40 T

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

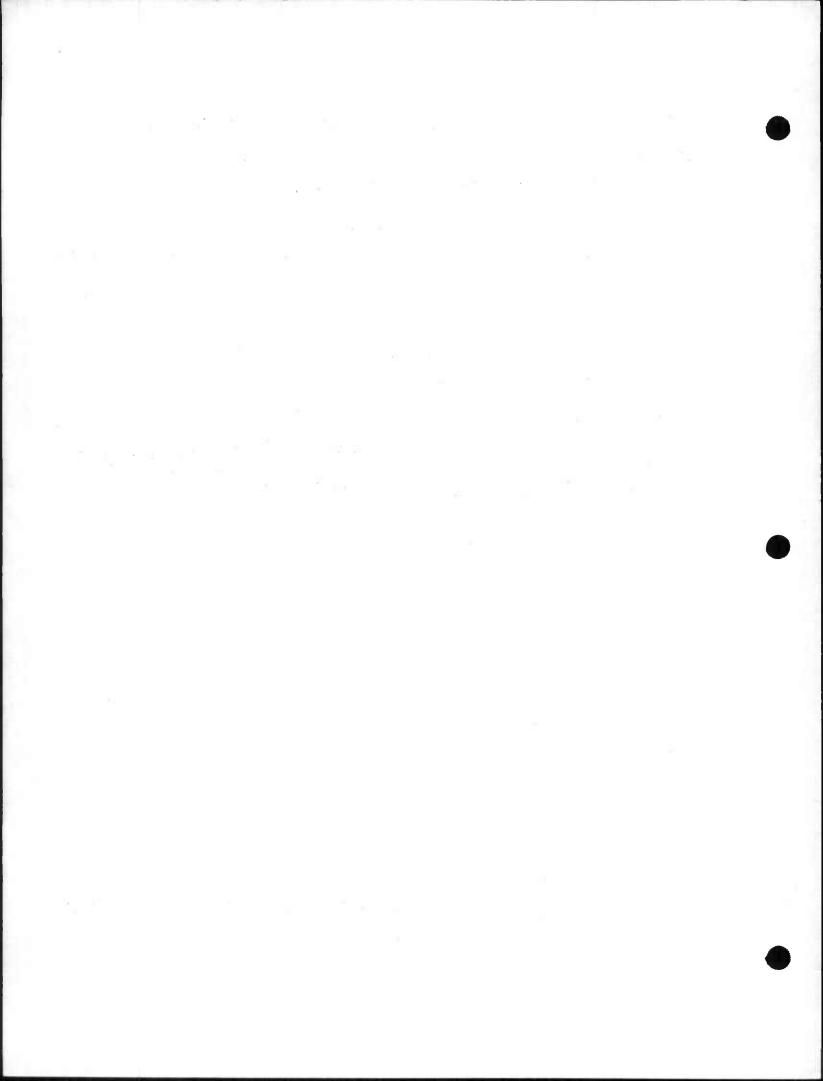


Amended #1, 11/2/95, SW, Calvert Co.

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

	1 - STATE REGISTRAR	STATE OF MARYL	_		F HEALTH OF DEAT		NTAL HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last) -DONALD	WILLIAM	Donald	ROBIN	SON, J		DATE OF DEATH	"31 1 ⁸	3. TIME OF DEATN 12:07 Am	
	4. SOCIAL SECURITY NUMBER 217 68 8624	5. SEX 6. AGE ((In yrs. lest birthday) YRS.	MONTHS DA		Mile.	onte of Birth (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) Maryland	
0. B		of RTE#524		96. CITY, TOWN OR LOCATION OF DEATH HUNTINGTON CALVERT						
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR L	OCATION				10d. INSIDE CITY LIMITS?	
	Maryland Cal		1	Hunti	ngtown				1 TYES 2 XNO	
FUNERAL	3840 Robinson	Road			2063	9		10g. CITIZEN OF WHAT C UNited S		
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS OECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2× X10	If ye		n, Mexicen, Pu	RIGIN? (Specify Yes serio Ricen, etc.)	or No- 14	RACE — American Indian, Black, Whita, atc. SpecifiWhite	
PLETED	15. DECEDENT'S EDI (Specify only highest grade Elementary/Secondary (0-12)		ille. Do NOT u	work done durin ise retired.)	g most of working	0	hoauts		TRY	
notified at once. TO BE COMPLET	Oddined I Tolloo									
TO BE	19a. INFORMANT'S NAME (Type/Print)						Number, City or Tow			
e e	Wm.Donald Robin					Maryland 206				
must	20e. METHOD OF DISPOSITION 1% Burlei 2 Cremellon 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetacy, crematory or after place) NOVEMber 3, DATE 1995 Barstow,									
medical examiner must	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE							eral Home PA	
al exa	23. PART I. Enter the diseases, or	100C	d the death for						t, Approximete	
event, the medi		List only one cause on a	ech Ilne.	د ج	mode of dyn	ng, auch as	Cordine or reap	natory arrow	Interval Between Onset and Death	
	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING									
or other	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.									
my Inju	PART II. Other eignificent condition	ne contributing to death b	but not reaulting	In the under	lying ceuse g	lven in Par	24a. WAS AMPERFO	RWED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
shows a							. 1 1 1 1 2 3		DF DEATH?	
AN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE C	26. PLACE OF DE	ES NC		ERTAIN [<u></u>	
SiC.	EXAMINER? XXYES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out		OTHER:	Home 5 □ Re	aldence 6 (2	Other (Specify)	SCENE	3	
PHY	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Yeer)	26b, TII	JURY	: INJURY AT WORK?		DESCRIBE HOW			
is marked D BY Pt	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJURY	Y — At home, farm,	12		-	LOCATION (Street	end Number or	Rural Route Number,	
28 T	4 Homicide determined	building, etc. (Spe				B	TH CAL	LVONT	60 Mg	
= 5	22	SICIAN: To the best of my know IER: On the besis of examination							cause(a) end manner es stated.	
MPORTANT: If	29b, IGNATURE AND TITLE OF CERTIFIE	Alarto				NSE NUMBER	3		SIGNED (Month, Day, Year)	
₹ 0	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Non-Print)								OBER 31,1995	
	JANUARIO D. KOREL LW 111 Penn Street, Baltimore, Maryland 21201									
	NOV - 2 199		wor Randall							



1 - STATE REGISTRAR

-	3	
UN ALLENDING PRISICIALY, THE LAW TOQUING UNIT DEADLY COLUMNICAL OF CACADICAL WILLIAM SAICH DEADLY, THESE OF THE DEADLY.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5	
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0110	y th	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 October 30 12:55 a M Geraldine J. Russell 7. DATE OF BIRTH
(Month, Day, Year)
June 13, 4 SOCIAL SECURITY NUMBER 5 SEY 8. BIRTHPLACE (State or Foreign 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN Pinehurst, NC 1 M 2 TF YRS. 578-54-4700 56 1939 Se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIPECTOR Holy Cross Hospital Silver Spring Montgomery 10e STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring 1X YES 2 NO Maryland Montgomery 104 STREET AND NUMBER 10f. ZIP CODE FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 20902 United States burial-transit 1115 Arcola Avenue etained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 1 Never Merried 2 Merried 1 TES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced use as the Black COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during met of working life. Do NOT use retired.)

Tersonnel 15 DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest Po Elementery/Secondary (0-12) College (1-4 or 5+) Staffing Specialist Government 12th once. 18. MOTHER'S NAME (First, Middle, Maiden Surname) 17. FATHER'S NAME (First, Middle, Last) Lillian McGregor John L. Jackson 7 BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 0 1115 Arcola Ave., Silver Spring, MD 20902 Debra D. Woods pe 20s. METHOD OF DISPOSITION

1X Buriel 2 Cremation 3 Removat from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Harmony Memorial Park 11/03/95 Landover, MD 4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23. PART is enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory strest, shock, or heart feliure. List only one cause on each line. medical Approximsts intervai Between Onset and Death IMMEDIATE CAUSE (Fine) CANCER UNG the 3 115 disease or condition resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST injury, or PART II. Other eignificent conditions contributing to deeth but not requiting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAR ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Item 23 shows any 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO YOUNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? SPITAL OTHER: 4 - Nursing Home 5 - Reeldence 6 - Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 6 28c. INJURY AT WORK? 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Netural 2 Accident 1 YES 2 NO BY Investigation 28e. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If Item 2 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner se stated. STORY STORY OF STORY D11463 29d. DATE SIGNED (Month, Day, Year)

> 10 - 30 - 95 BE 2 BRICE A. SILVER, MD 210 MESICAL PARK DR, SILVER SPRING, MD 20902

32. BEGISTRAP'S SIGNATURE

Jalia d'Estalepe Randell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

-

attending physician. use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for u	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
			1

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
MAE	Е.		Rob	ine	tte			October May 19 1995 10:20P M				
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF	BIRTN		8. BIRTH	IPLACE (State or Foreign
208-10-2396	1 🗌 M 2 🗶 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	SEPT.	29,	190	PE	NNSYLVANIA
9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY,	TOWN C	TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH				EATH		
MEMORIAL HOSPI	TAL			EASTON					TAL	BOT		
RESIDENCE OF DECEDENT												
10a. STATE 10b. COUNTY			10c. CITY,									10d. INSIDE CITY
	N ANNE	S	CH	URC								1 YES 2 NO
1646 ROBERTS S	TATION	ROAD			101	21 C	623			10g. Cl	USA	WHAT COUNTRY?
11. MARITAL STATUS		NT EVER IN U.S. AR						NIC ORIGIN? (S		or No-	14. RACI	E — American Indian, k, White, atc.
1 Never Married 2 Married 3 Widowed 4 Divorced		YES 2 X	io.			2 X NO		an, Puerto Rica fy:	n, etc.)		Spec	
15, DECEDENT'S EDU	CATION	18a. DE	CEDENT'S L	JSUAL OC	CCUPATIO	ON		16b. KII	ND OF BUS	SINESS/IN	DUSTRY	WILLE
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	life	to kind of we Do NOT use	ork done o retired.)	during mo	ost of work	ing					
12			OMEM	AKE	R				OWN	НО	ME	
17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname)												
JOSEPH G. CLAAR 196. INFORMANT'S NAME (Npe/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
19a. INFORMANT'S NAME (Type/Print) SANDRA CROSSMA	AN											HILL MD
20a METNOD OF DISPOSITION 1 N Burial 2 Cremation 3 Rem	•	20b. PLACE cemetery, cre			ITION (No	eme of		DATE	20c. LO	CATION -	- City or Ti	own, State
4 🗆 Donation 6 🗀 Other (Specify)		HOLSI	NGER	CE					BAK	ERS	SUM	MIT, PA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A.												
NOHN R	MERCH	5001	ECP									N MD
23. PART i. Enter the disesses, or	complications th	st ceused the de	ath. Do no									Approximate
shock, or heart failure.	List only one ca	use on each line	9.									Onset and Death
IMMEDIATE CAUSE (Finsi disease or condition	P	GALA-1	F	AI	-6	UR	E					YRC
resulting in death)	DUE TO	ENAL O (OR AS A CONSE	OUENCE OF):								1102
	, Co	NGG	STA	-V/2	2 /	46,	12	TFA	ILI	UR	E	
Sequentisity list conditions, if sny, leading to immediate		OR AS A CONSE										
cause. Enter UNDERLYING CAUSE (Disease or injury		ERIPI-			V	MS	cu	LLAR	- D	15	13	
that initiated events resulting in death) LAST	DUE TO	O (OR AS A CONSE	OUENCE OF):								
resulting in death) Exst	d											
PART II. Other significant condition	ne contributing to	o death but not	resulting is	n the ur	nderlyin	g ceuse	given in	Part I. 24	le. WAS AN		7 24	b. WERE AUTOPSY FINDINGS
CORONA	HRY	HEA-R	277	273	Q A	SE		١.	PERFO			AMAILABLE PRIOR TO COMPLETION OF CAUSE
A . A	LAR	HEAT	2	NI	< F	AS	6	'	_ 1E9 /	· you		OF DEATN? 1 □ YES 2 NO
DID TOBACCO USE CONT			TH YE	- / /		1		NΠ				I LES NO
25. WAS CASE REFERRED TO MEDICAL	T TO C		CE OF DEAT	_			CERTA					
EXAMINER?	HOSPITAL:	☐ ER/Outpetlent :	DOA	OTHER		me 5 🗆 F	Residence	6 Other (S	Specify)			
27. MANNER OF DEATH	26a. DATE C	F INJURY	28b. TIME	E OF	28c, IN	JURY AT		28d. DESCR		INJURY O	CCURED	
1 Natural 5 Pending Investigation	(Month,	Day, Year)	INJ	M		ORK? YES 2	□ NO					
2 Accident Investigation 3 Suicide 8 Could not be		OF INJURY — At h	oma, farm, a	treet, fact	tory, offic	ca					er or Rural	Route Number,
4 Nomicide determined	pulloling	g, atc. (Specify)						City or	Town, State	,		
29a. CERTIFIER (Check only one)												(a) and manner as stated.
2 MEDICAL EXAMIN		exemination and/or	vee(igatio	ii, iii my (ориноп,	T			ru piece, 8i			
29b. SIGNATURE AND TITLE OF CERTIFIE	VAAO -	MX				29c. LI	CENSE NU	DH7	2	29d. D	ATE SIGNE	20 95
30. NAME AND ADDRESS OF PERSON W	NO COMPLETED CA	USE OF DEATH (ITI	M 27) (Type.	Print)		ره۱	12	0.10			(V	2-113
ERIC E CICANI	K. M.D	. 109	S. C	OMM	ERC	E S	т.,	CENT	REVI	LLE	, MI	21617

32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) OCT 25 1995

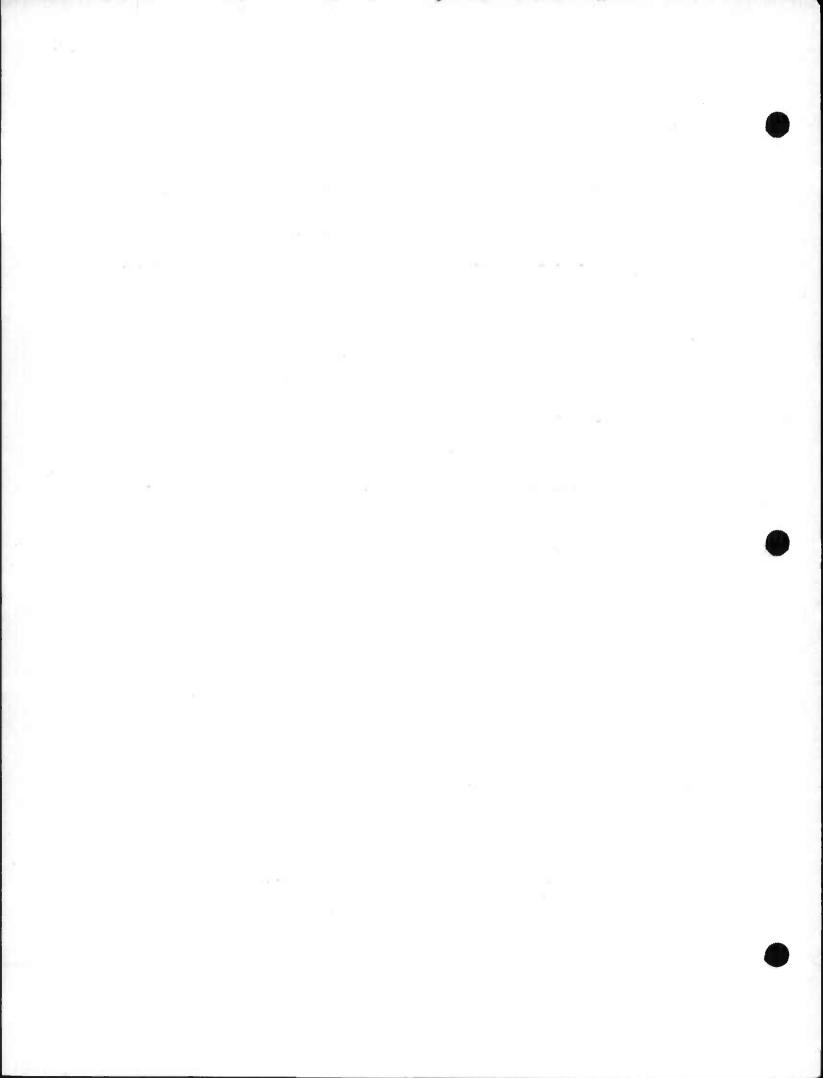
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FOR STATE REGISTRAR

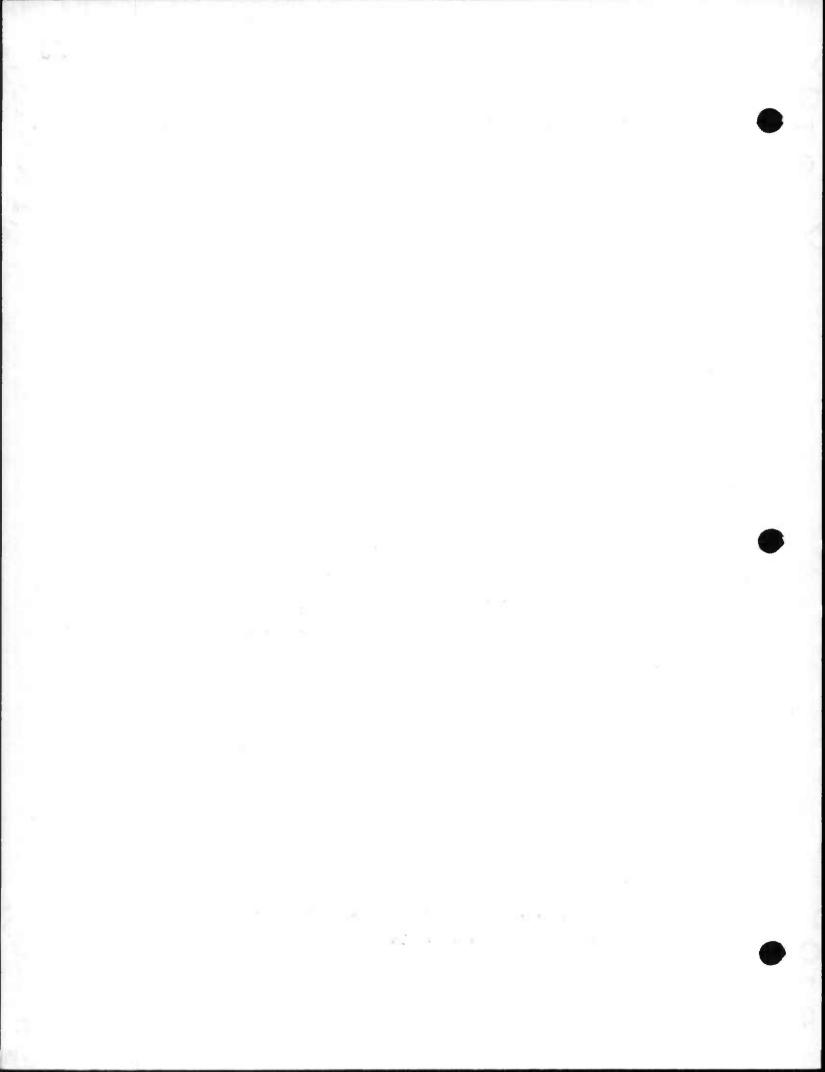
1. DECEDENT'S NAME (First, Middle, Last)

		1. DECEDENT'S NAME (First	, Middle, Last)									2. DATE O	F DEATH	м.	VE40	3. TIME OF DEATH
		John			D	aniel			Sut	ter		Nove	nber Ö	3, 1995	YEAR	11:27 A: M
		4. SOCIAL SECURITY NUM	BER	5. SEX	5. SEX 6. AGE (In yrs. lest birth			y) IF UNDER t YEAR IF UNDER 24 HRS.				7. DATE OF	BIRTH		S. BIRTHE	PLACE (Stete or Foreign
		219-56-0533		1 🔀 M 2 🗌 F		44	YRS.	MONTHS	DAYS	HOURS	MIN.	Febru	Day, Year) arv27	.1951	Country	hington,DC
3 should	ł	9e. FACILITY NAME (If not it			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											
2, 3 sl	NO B	2656 Hunt Pla	ace					Waldorf Charles								
	5	RESIDENCE OF DE	10b. COUNT				10c, CITY,	7011010								
Page .	DIRECTOR			None							7					10d. INSIDE CITY LIMITS?
mit.		None		None			Was	PITTIG	_	, DC						1 XYES 2 NO
physician. burial-transit permit. Pages 1.	FUNERAL	1133 20th		M an	t. 2	50			101	2003				99		HAT COUNTRY?
trans	뷀	11. MARITAL STATUS	DC. IV.	12. WAS DECEDER			MED	12.1	MS DEC			NIC ORIGIN?	/Coople Voc	U.S		- American Indian,
ohysic	- 11	1 Never Merried 2	Married	FORCES?	1 YES	2X N		1	yee, sp	ecify Cub	an, Maxica	in, Puerto Ric		01 140-	Bleck	White, atc.
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ched	COMPLET	10		0		р	ainte	er/ha	indy	man			priva	te		
detach once.	8	17. FATHER'S NAME (First, A								1		ME (First, Mi		Surname)		
d by	BE	Marshall R		utter								Alr				
retained by the hospital of 5 should be detached for notified at once.	2	19e. INFORMANT'S NAME (1						Route Numbe				
y be nage 5	- 1	Timothy H				1	II Ro	se (ard	en W	lay,	Frede	-			
ector, pa		20e. METHOD OF DISPOSIT		oval from State			ND DATE O					DATE		CATION — C		
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min Peral	20e. METHOD OF DISPOSITION 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Burlai 2* Exemetion 3 Removal from State 4 Donetton 6 Other (Specify) 1 Exemption of other place) 1 Durant Unit of Full Rail, SERVICE LICENSEE 1 Durant Unit of Full Rail, SERVICE LICENSEE 2 NAME AND ADDRESS OF FACILITY Lee Funeral H 6633 Old Alexander Ferry Rd. Clinton, MD 20735 2 Specific Rail Rail Rail Rail Rail Rail Rail Rail									T HC	me, Inc.					
al.		Xet	ale					Ci	int	on.	MD 2	0735	rerr	y Ru.		
d in by the or removal medical		23. PART . Shiter the c		complications th									sc or respi	ratory arre	est,	Approximats
Hed ir		IMMEDIATE CAUSE (FI		Controlly bile co	use Dire	-										Interval Batween Onset and Death
within 24 upletely fille cremation, vent, the		disease or condition	\rightarrow	1)(Ng		JUE	DUSH								Millinks
d with				DUE TO	OR IS	CONSE	OUENCE OF):								
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremat IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, I	N	Sequentially list condi	tiona	b							•					
be exitan a pr to aum	Ĕ	if any, leading to imme cause. Enter UNDERLY	diate	DUE TO	O (OR AS /	CONSE	DUENCE OF):								
icate physic ne pri	5	CAUSE (Disease or inj		c. DUE TO	OR AS	CONSE	DUENCE OF)·	_							
ding ding lygier	ERTIFICATION	that initiated events resulting in death) LAS	ST T		(011707	. 0011021	JOENIOE OF	,-								į
atten atten atten mtal h	E			d												
the y the Inju	AL	PART II. Other aignific	ent condition	na contributing to	o deeth b	out not i	esulting in	n the un	derlyin	g cause	given in	Part i.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
s that ned b lifth at	MEDICAL											_	1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?
quire in sig if Hea	ME											_/	/			1 YES 2 NO
law re is bee ept. c	ä	DID TOBACCO (RIBUTE TO CA	AUSE C						CERTAI	N D				
The ate his ten	PHYSICIAN:	25. WAS CASE REFERRED ' EXAMINER?	TO MEDICAL	HOSPITAL:		26. PLAC	E OF DEAT	OTHER			,					
CIAN: ertific the Si	ΥS	1 YES 2 NO		1 Inputiont 2		patient 3		4 🗌 Nun	ling Hon		Residence	6 Other				
his c with with ked,	표		Pending	26a. DATE O (Month,	Day, Year)		28b. TIME INJU	URY	W	JURY AT	¬l.,	28d. DESC	RIBE HOW I	NJURY OCC	URED	a note.
ther the eath	BY	2 Accident	Investigation	28e. PLACE	OF IN IUD	/ As h-	10:4	_	1 🗍		No	000	1 dvota	17.0-0	1W	WOWL
OR: / fter of	E	3 Suicide 6 4 Homicide	Could not be determined	building	, atc. (Spe	cify)	**************************************	treet, lect	ory, ornic	: -			TiON (Street of Town, Stete)		or nor al h	oute number,
IRECTIONES OURS O	Ē	29e. CERTIFIER		VA			_		- 1							
TAL O	MPI	(Check only		SICIAN: To the best of												
UNE VITTIN	COMPL				@AMITHITIATIO	in end/or	ILIA BRII BRII O	n, in my c	pinion,	seath occ	ured at the	time, date o	end piece, er	a due to in	e ceuse(e	end menner ee stated.
THE Filled V	BE	29b. SIGNATURE AND TITL	OF CERTIFIE	R	Λ.	. 12-	1.1			29c. LIC	CENSE NU	MBER		29d. DATE	SIGNED	(Month, Day, Yeer)
₽ ₽ g ¥	0	FRVVV		1 (3 C)	Dep	hte	lac	C		(F)	417	70		- 1/	415	1-
		30. NAME AND ADDRESS O	F PERSON WI	1/ - D	SE OF DE	1 A	M 27) (Туре,	Print)	11.		1	1	206	nx		
		31. DATE FILED (Month, Day	Year)	32. R€GISTR	AB'S SIE	ATURES	1	N 6	NI	225	1	DV.	UDA	4		
		NOV 0	7 1995	32. BEGISTE	davel	work!	erdall				•					
																DUMB 10 Day 17

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



	FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAN	ID / DEP/					MENTA			J	34000
	1. DECEDENT'S NAME (First, Middle	e, Lest)			CERTI	FICAL	E OF	DEA	ın	2. DAT	REG. NO			3. TIME OF DEATH
	Georgianna	Stou	ulil SCH	MID							tober ?	24. 1	995	11:35 P. M
	4. SOCIAL SECURITY NUMBER		5. SEX	B. AGE (In y	rs. lest birthda		R 1 YEAR	-	R 24 HRS.	7 DATE	OF BIRTH th, Day, Year)		8. BIRT	HPLACE (State or Foreign
	577-18-8341		1 🗌 M 2 🔀 F	8	1 YRS	MONTHS	DAYS	HOURS	ARTH.	Apr	. 8, 1	914	Was	hington, DC
m	9e. FACILITY NAME (If not Institution		W W W			9b. CIT	Y, TOWN	OR LOCAT	ION OF D	EATH			NTY OF	
ē	Doctor's Commu	init;	y Hospit	al		La	anha	m				Pri	nce	George's
DIRECTOR		COUNTY			10c. 0	ITY, TOWN	OR LOCA	TION						10d. INSIDE CITY
		ince	George'	S	Ri	verda	ale							1 YES 2 X NO
3AL	10e. STREET AND NUMBER						10	f. ZIP COD	E			10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	6626 Powhatan						_	2073					ted	States
	11. MARITAL STATUS 1 Never Merried 2 X Merrie		12. WAS DECEDEN FORCES? 1	YES 2	2 X NO		If yes, sp	pecify Cubi	m, Mexics	an, Puerto	N? (Specify Yellian, etc.)	or No-	14. RAC Blac	CE — American Indian, ck, White, etc.
ВУ	3 Widowed 4 Divorced		IF YES, GIVE V	WAR OR DATE	s		1 YES	5 2 X NO	Specif	fy:			Spe	White
COMPLETED	15. DECEDENT (Specify only higher			16	ie. DECEDENT	'S USUAL C			00	160	b. KIND OF BU	SINESS/IN	DUSTRY	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
E E	Elementary/Secondary (0-12)		College (1-4 or 5		life. Do NOT	use retired.)		out or world	· · · · · ·	Ι,		_		
M M	12 17. FATHER'S NAME (First, Middle, L			1 2	Seamst	ress					Private		lust	ry
E CC	Edgar Joseph S		111								Middle, Melden Bain	Sumame)		
m	19e. INFORMANT'S NAME (Type/Prin				19b. MAILI	NG ADDRES	S (Street				nber, City or Tow	n. Stata. Zii	n Code)	-
2	Henry F. Schmi	ld			2.6									and 20737
	20e. METHOD OF DISPOSITION 1													
	4 Donation 5 Other (Specification of Specification of Spe	y)	3/1 //2/2004	- Fo	rt Lir	coln	Cre				/95 Br	entwo	od,	Maryland
	Fort Lincoln Funeral Home, Inc.													
	Rash Julius 3401 Bladensburg Rd., Brentwood, MD 20722													
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, IMMEDIATE CAUSE (Final disease or condition resulting in death) a. And out of the mode of dying, such as cerdiec or respiratory strest, Approximate Interval Between Onset and Death Immediate Immediate													
			(July 10	(OR AS A CO	MINITUENCE	OF)	1. 1	/	1					101
NO NO	Sequentially list conditions,	T 6	DUE TO	ION AS A CO	INSEQUENCE	17	ny	nor	_		1			10 days
CAT	If any, leading to immediate cause. Enter UNDERLYING	J.,	Cong	est	me	- 1	he	ul	- 5	tas	lus	(10 days
Ē	CAUSE (Disease or Injury that initiated events) .	gue/19	KOR AS A CO	NSEQUENCE	09./		00	1					1.00
CERTIFICATION	resulting in death) LAST	a.	ut	20	C/	UB.	2/1	ces	NA					1000
اندا	PART II. Other significant con	nditions	contributing to	death but a	not resulting	in the ur	nderlyin	g cause	given in	Part I.		AUTOPSY	240	WERE AUTOPSY FINDINGS
MEDICA											PERFOR	. 1		AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME												^		1 THE 2 NO
ä	DID TOBACCO USE C		BUTE TO CA			ES 💆	-	JUNC	ERTAI	Ν□				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDI EXAMINER? 1 TYS 2 NO		HOSPITAL:		PLACE OF DE	OTHE								
HYS	27. MANNER OF DEATH		1 Inpatient 2 28e. DATE OF			4 Nu	_	OURY AT	sidence		SCRIBE HOW I	N #IPW OO	CHEE	
	1 Netural 5 Pending		(Month, D	ay, Year)	1	NJURY M	WC	YES 2	NO	200.00	SCHIDE HOW I	NJOHT OC	COHED	
D BY	3 Suicide 8 Could r		28e. PLACE O	F INJURY — i	At home, ferm	, street, fec				281. LOC	CATION (Street I	and Number	or Rural	Route Number,
	4 Homicide determi	Ined	o and ing,	eta (apocny)						City	or Town, Stete)			
COMPLETED	29e. CERTIFIER (Check only	HYSICI	AN: To the best of	my knowledg	e, death occu	rred at the t	time, date	end place	, end due	to the ca	use(e) end mar	ner ee ata	led.	
Š	one) 2 MEDICAL EX	AMMEN	n the basis of e	camination en	d/or investiga	tion, in my o	opinion, d	leath occur	red at the	time, date	e and place, en	d due to th	e ceuse(e) end manner ee stated.
BE 0	296. SIGNATURE AND TITLE OF EE	multiple						29c, LICI	ENSE NUM	MBER		29d. DAT	E SIGNE	(Month, Oky, Year)
0	()178	N/Z						10	198	19/		> /	0/2	5/95
	30. NAME AND ADDRESS OF PERSON Abraham Dabela						R	iver	dale	. MD	20737		1	
	31. DATE FILED (Month, Day, Year)		32. REGISTRA							,				
	OCT 311	995	Julia	I WOULDS	- NAME									



		1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPAR	RTMENT	OF HE	EALTH AND	MENTA	L HYGIE		
		1. DECEDENT'S NAME (First, Middle, Last) \$\(\big) \\ \bi	N S	MITH				MONT	OF DEATH	DAY	YEAR 3. TIME OF DEATH
3 0/3		578-44-0464	1 □ M 2 🙀 F	yrs. lest birthday) 65 YRS.	IF UNDER 1		IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont	OF BIRTH h, Day, Year) 26 19	1	BIRTHPLACE (State or Foreign Country) Pitt Cnty, N.C.
3 0/3 should 8	тон	RESIDENCE OF DECEDENT	YIAND HOSP.	ITAL	9b. CITY, T	1	NON	EATH		100000	INCE GEONGE
permit. Pages	DIRECTOR		e Georges	10c, CIT	y, town or		on, Mary	yland	1		10d, INSIDE CITY LIMITS? 1 X YES 2 NO
ist.	NERAL	9601 Pineview Lan	12. WAS DECEDENT EVER IN U.			1111	20735			Unit	ed States
a g	BY FUNI	1 Never Merried 2 Merried 3 Widowed 4 Divorced	I.S. ARMED 2 W NO ES	11/3	yes, spec	INDENT OF HISPAR cify Cuben, Mexice 2 X NO Specify	n, Puerto	i? (Specify) Ricen, atc.)	es or No- 1	4. RACE — American Indian, Black, White, etc. Specify: Black	
ital or attendi	LETED			6a. DECEDENT'S (Give kind of a life. Do NOT us	work done dui se retired.)	ring most	t of working	168		USINESS/INDU	STRY
TLAND by the hospit be detached at once.	COMPL	12 17. FATHER'S NAME (First, Middle, Last) Richard Loary		Tea	chers		18. MOTHER'S NA	Dept. Of Education R'S NAME (First, Middle, Malden Surneme)			
retained by 5 should b) BE	Richard Leary 190. INFORMANT'S NAME (Type/Print)	Marth d Number or Rural I			111iams					
2 5 10 2 1	욘	Richard Smith					ale Way				
Page 6 may be all director, page ner must be r		20e. METHOD OF DISPOSITION 1X Burisi 2 Commatton 3 Removi 4 Donation 5 Other (Specify)	ral from State cemeter	ACE AND DATE OF THE COLOR OF TH	Memor	ial	Park	10/			over, MD
death. e funera		21. SIGNATURE OF PURENAL SERVICE CICEN	Page X	•	A 5	1exa 538	ander S. Marlbon	Pop	ke Fo	restvi	lle, MD 20747
y filled in tition, or r		23. PART I. Entar the diseases, or corehock, or heert fellure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	Plus 10 Au s	y Ma	n	he mode	e of dying, suc	h as care	flec or rea	piratory arres	Approximata Interval Between Onset and Death Amonth
executed and con burial.	CATION	Sequentially list conditions, if any, leading to immediate	MW19 J OUE TO (OR AS A CO	H y Pe	P: 600						May yes
certificat ding phy Hygiene p	RTIFI	ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	OUE TO (OR AS A CO		g and						2-3 y-
2 8 8 5	AL CE	PART II. Other algnificant conditions	contributing to death but	not resulting	in the unde	erlying	cause given in	Part I.	24s. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS
w requires that the speed signed by the pt. of Health and 13 shows any in	MEDICA							_	PERFO	PRIMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
Pease 2	AN	DID TOBACCO USE CONTRII		PLACE OF OEAT			UNCERTAIN	N			<u> </u>
E 8 8 5	YSICI	EXAMINER?	HOSPITAL:		OTHER:		5 🗆 Residence	6 🗆 Othe	r (Specify)		
NE PHYSICIAN: The this certifical salb with the St marked, or it	F	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year) N/A		URY	8c. INJUI	K?	28d. OES		INJURY OCCU	RED
Ditys death s ma	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify)				S 2 NO	261. LOC City	N/A ATION (Street or Town, State	t end Number or	Rural Route Number,
AL DIRE	COMPLET		AN: To the best of my knowledg	ge, death occurre	ed at the time					enner es atated	
HOSPITAL FUNERAL WITHIN 72 TTANT: II		2 MEDICAL EXAMINER:	On the basis of examination an	id/or investigatio	n, in my opir		ith occured at the		end place, e	Y	
TO THE HOSPIT TO THE FUNER De fied within 7	TO BE	K. Dance				8	D25-6 4	4D		DO S	BIGNEO (Month, Day, Year)
3)		K HOSADW DA	AVACHI 1	13285	Print)	162	N AVE	NUE	S	E. WI	20032 ASHINGTON DC
2		OCT 31 1995	A. AEGIS WAR'S EIGHAT								

filled in by the funeral director, page 5 should be detached for use as the burial-transft ion, or removal.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	W.	S	ept.	23
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	Let med within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or re	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the med
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34857 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATH tranc October 28 ,1995 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) Sept. 7,1934 Maryland 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 24 HRS. 1. BIRTHPLACE (State or Foreign DAYS 217-30-9200 1 M 2 X F 61 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dorchester General Hospital Cambridge Dorchester 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Dorchester Cambridge 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WNAT COUNTRY? 514 Muir Street 21613 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES If yea, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married 2 X NO BY Specify. 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Sales Representative Telephone Company 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) George Cornish BE Leila Pinkett 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ Glenda Sharp-Vaughn 27193 Pinebrook Ter. Hebron, Maryland 21813 20s METHOD OF DISPOSITION

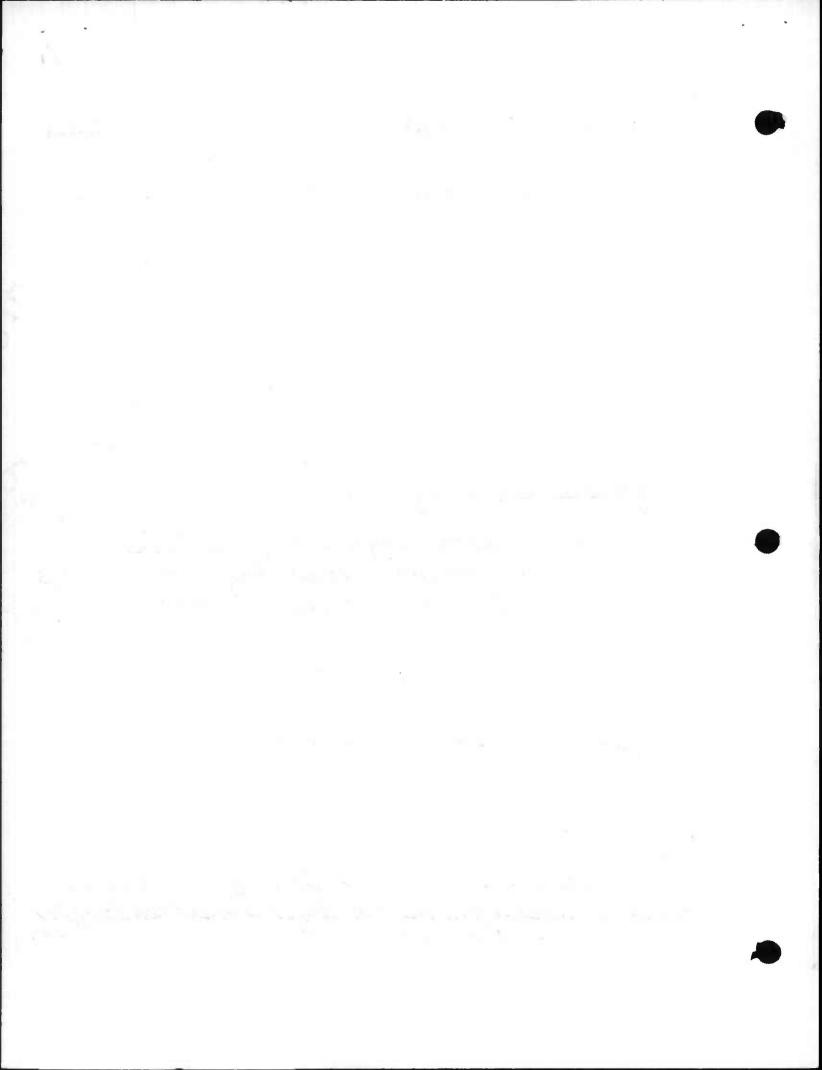
1 Surlet 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Waugh <u>Cemetery</u> 11/2 Cambridge, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Henry Funeral Home Du o Washington St.Cambridge.Md 23. PART | Entar the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or haart failure. List only one cause on each line. intarval Between **IMMEDIATE CAUSE (Final** Onset and Death disesse or condition resulting in death) CERTIFICATION Sequantially list conditions, if any, lasding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN:

5. WAS CASE REFERRED TO MEDICAL	ITRIB	26. PL	ACE OF DEA	TH (Check	confy one)			
EXAMINER?		OSPITAL: Inpatient 2 ER/Outpatient	3 🗆 DOA	OTHE	R:	6 Other	(Specify)	
7. MANNER OF BEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2		WORK?	28d. DEŞCRIBE HOW INJURY OCCURED				
2 Sa. PLACE OF INJURY — At home, farm, street, factory, building, stc. (Specify)				actory, offica 28f. LOCATION (Street and Number or Rural F City or Yown, State)		Rural Route Number,		

2 MEDICAL EXAMINER: On the beals of examination	and/or investigation, in my opinion	n, death occured at the time, dat	le and place, and due to the cause(s)	and manner as stated.

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ZIE SKUMATNIE AND TITLE OF CENTIFIER	29c. LICENSE NUMBER	THE PARTY SECURITY (March Clay Stars)
Successionative and title of centifier Washington 1	10 D3/108	ever some member (month, 194), 1949)
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ges 1, 2, 3 should

TO THE HOSPITAL TO THE FUNERAL DE FILED WITHIN 72 h

31. DATE FILED (Month, Day, Year) NOV 0 8 1995

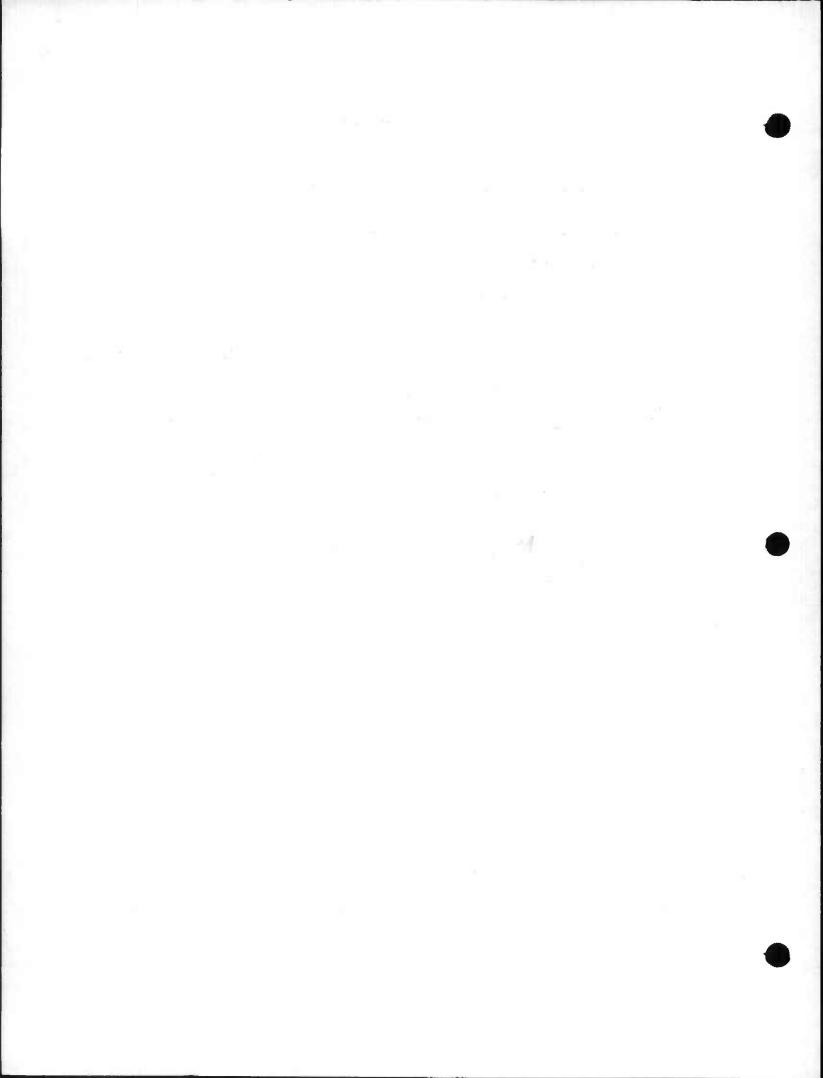
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pr	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DR ATTENDING PHYS	DIRECTOR: After this c	nours after death with	tem 28 is marked,
THE HOSPITAL	THE FUNERAL	filed within 72 h	PORTANT: If I

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR November 6.1995 James 7:13 Scribner David p 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) April 27 8. BIRTHPLACE (State or Foreign 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS HOURS 091-40-9992 1 💢 M 2 🗌 F 46 1949 New York 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 405 Prospect Street (Residence) La Plata Charles 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Charles La Plata 1 YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 405 Prospect Street U.S.A. 20646 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 X Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programer Power Production 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gordon Victor Scribner Laura Leibolt Scribner Leach 194, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Paula J. Scribner 405 Prospect Street La Plata, MD 20646 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Metropolitan Crematory 11/11 Alexandria, VA 21. SIGNATURE OF FUNERAL ŞERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MQ0817 Arehart-Echols Funeral Home 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 567 La Plata, MD 20646 interval Between Onset and Death IMMEDIATE CAUSE (Final diseese or condition MESOTHELIOMA MALIENAMY 8 Mo resulting in death) DUE TO (OR AS A CONSEQUENCE OF MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 INO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 | Inpellant 2 | ER/Outpellent 3 | DOA OTHER:
4 | Nursing Home & Realdence 6 | Other (Specify) 1 YES 2 NO 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED Naturel 5 Pending Investigation BY 1 YES 2 NO 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Sulcida 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide t DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day Ybar) BE Mal Wish D-28352 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Krishan Mathur,MD Cambridge Professional Center #102 3500 OLd Washington Road Waldorf,MD 20602

32 MES TRANS SIGNATURE RANGEL



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It liem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 . STATE

- 2	REGISTRAR		CERTIF	ICALE	OF DE	AIH	REG. NO				
MPLETED BY FUNERAL DIRECTOR	1. DECEOENT'S NAME (First, Middle, Last)			CMEDITENC			2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH OCt. 30 1995 3:06 a				
	DOROTHY CANTERBURY 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last			STEPHENS t birthdsy) IF UNDER 1 YEAR IF UNDER 24 HRS.			Oct. 30		95 3:06 a M		
					DAYS HOU		(Month, Day, Year)		Country)		
	346-09-8510	1 - M 2 X F 77	THS.				Aug.9,1918		llinois		
_	9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, T	OWN OR LO	CATION OF DE	EATH	9c. COUNTY	Y OF DEATH		
6	Memorial Hospital at Easton			Easton				Talbot			
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	10c CI	TY TOWN OR	LOCATION				10d. INSIDE CITY			
E	Maryland Talb		10c. CITY, TOWN OR LOCATION				LIMITS? 1 YES 2 XNO				
- 1	100. STREET AND NUMBER	1.	Tilghman 101, ZIP CODE				N OF WHAT COUNTRY?				
	The state of the s										
	4934 Fairbank Rd.		21671					S.A.			
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES	2. NO	lf y	yea, specify (Cuban, Maxica	NIC ORIGIN? (Specify Year, Puerto Rican, atc.)	or No — 14	I. RACE — American Indian, Black, Whita, atc.		
B	3 X Widowed 4 Olvorced	ATES	1 TES 2 NO Specify:				Specify White				
	(Specify only highest grade	(Give kind of	DENT'S USUAL OCCUPATION Inited of work done during most of working NOT use retired.) NOT use retired.)								
	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Intonic	Homemaker							
N		1	Interio	or Dec							
	17. FATHER'S NAME (First, Middle, Last)	_			16.		ME (First, Middle, Maiden	Surname)			
TO BE	Lewis Canterbury		1				a Cook				
	19a. INFORMANT'S NAME (Type/Print)						Route Number, City or Tox		20013		
	Mary C. Stephens						I. Chevy Ch				
	20e. METNOD OF DISPOSITION 1 □ Buriel 2X Cremetion 3 □ Rem	ioval from State CBI	b. PLACE AND DATE	of OISPOSIT	ION (Neme of		DATE 20c. LC	CATION — CIF	y or Town, State		
	4 Donetion 5 Other (Specify)		apitol (remat	ory l	Nov. 1	, 1995 Do	ver, I	Delaware		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harrison E. Leonard Funeral Home										
	312 S. Talbot St. St. Michaels, Md. 21663 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximates										
BE COMPLETED BY FUNERAL		List only one cause on					.,		interval Between		
	IMMEDIATE CAUSE (Final										
	disease or condition a. ACUTE INTERIOR Myocandial Infarcino 8has Due to (or as a consequence of):										
	DUE TO (OR AS A CONSEQUENCE OF):										
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ATION	If any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE	EOUENCE OF):							
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	C	A CONSEQUENCE								
	that initiated events resulting in death) LAST	DOE TO (OR AS	A CONSECUENCE	OPJ:					i II		
ER	d.										
BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL	PART II. Other significent condition	ns contributing to deeth	but not resulting	In the und	lerlying csu	use given in			24b. WERE AUTOPSY FINDINGS		
	14. 25 Chalent	PERFORMED? MAILABLE PRIOR TO COMPLETION OF CALIFE									
	1 YES 2 DINO										
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN I										
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:										
	1 NES 2 NO	1 12 Inpatient 2 - ER/Out		-			6 Other (Specify)				
PH	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)		NJURY	28c. INJURY WORK?		28d. DESCRIBE HOW	INJURY OCCU	RED		
	1 Natural 5 Pending 2 Accident Investigation			М	1 TYES	2 NO					
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY FUNERAL DIREC	3 Sulcide 8 Could not be		 PLACE OF INJURY — Al home, farm, atree building, atc. (Specify) 				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	4 Homicide determined										
	29s. CERTIFIER (Check only) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end manner se stated.										
M	one) 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, data end placa, end due to the cause(s) and manner as stated.										
	296, SIGNATURE AND SITLE OF CERTIFIER 296, DATE SIGNED (Asset), Day, Year)										
BE	12/11	- 00	290. LICENSE NUMBER			111	11 Dokolo				
	TO NAME AND ADDRESS OF PROSON W	C COMPLETED CAUSE OF D	EATH HITEMAN	Ba Prines	1	111	00	14	-///		
	LV dwilg J, Es /scalente mp 606 DUTCH mans LANE CASTON Md 2/601										
	LVONIGO, ESSCORRIEMO GOG DILLA MANS LANG CONSIDER CONTROL CIGOS										
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 02 1005 Salva Baurelean Revolution										
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TO BE COMPLETED BY FUNERAL DIRECTOR

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR	STATE STATE OF MARIE LAND / DEFARIMENT OF REALITY AND MICHIAL IT GIENE											
1. DECEDENT'S NAME (First,	Middle, Last)						2. DATE	OF DEATH		EAR 3	. TIME OF DEATH	
MARY		MA	E	5	SHERWOO	D	Nov	_	1995		2:02 p*	
4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER 1 YEAR	IF UNGER 24 HRS. HOURS MIN.	7. DATE (DF BIRTH Day, Year)	8.	Country)	ACE (State or Foreign	
216-38-76		1 M 2 F	80	YRS.		OR LOCATION OF DI		. 14, 1	915 9c. COUNTY	MAF	RYLAND	
MEMORIAL RESIDENCE OF DEC		EASTON					TALBOT					
10e. STATE	10b. COUNTY			toc. CITY	Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?			
MARYLAND 100. STREET AND NUMBER	TALB	ОТ		EASTON 101, ZIP CODE				10a. CITIZEN			1 X YES 2 NO	
8565 KING	s cou	RT		216			.601 U			A		
11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EYER II FORCES? 1 YES IIF YES, GIVE WAR OR 0.				25 TO It yes, specify Cuben, &			ben, Mexican, Puerto Rican, atc.)			I4. RACE American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working (file Do NOT use refined) 16b. KIND OF BUSINESS/INDUSTRY												
Elementary/Secondery (0)-12)	College (1-4 or 5 +)		NT SIT	ER		HEALT	н саг	RE		
17. FATHER'S NAME (First, M	liddle, Last)		1 1.	TIL TIME	VI DII.	18. MOTHER'S NA						
JAMES ALE	RED A	LLEN				BLANCI	HE E	DNA C	ANNON	ī		
19e. INFORMANT'S NAME (1				19b. MAILING	ADDRESS (Street	and Number or Rural	Route Numb	per, City or Town	, State, Zip Go	ode)		
THOMAS D.	SHER	WOOD		8565	KINGS	COURT,	EAS	TON,	MD 21	601	L	
20e. METHOD OF DISPOSIT	ION on 3 - Remo	oval from State			of disposition (A	ame of EMETERY	11-		DOVA.			
21. SIGNATURE OF FUNERA			DI.	OODIII	22. NAME A	ND ADDRESS OF FA	CILITY					
>			~	-		M FUNE		-			1470	
		ERCER:				HARR						
shock, or h	Approximate shock, or heart failure. List only one cause on each line. MMEDIATE CAUSE (Fine) Neasse or condition									interval Between		
reaulting in death)	•	OUE TO	(OR A CONS	SEQUENCE OF	F):	ufu l					200	
						•						
Sequentially list condit if eny, leading to imme		OUE TO	(OR AS A CONS	EOUENCE OF	F):				_			
cause. Enter UNDERLY CAUSE (Disease or Inju		n										
that initiated events resulting in death) LAS		DUE TO	(OR AS A CONS	SEOUENCE OF	F):							
resulting in death) LAS	"	d										
PART II. Other eignifica	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE									AVAILABLE PRIOR TO COMPLETION OF CAUSE		
							_	t TYES 3	7100		OF DEATH?	
DID TOBACCO U	ISE CONTI	RIBUTE TO CA				_	N□					
25. WAS CASE REFERRED 1 EXAMINER?	O MEDICAL	HOSPITAL:	/		TH (Check only one OTHER:		51511					
1 YES 1 NO		1 Inpatient 2gd		28b. TIM		JURY AT		r (Specily) SCRIBE HOW II	WILLIBA OCCIT	BED		
	Pending	(Month, D			JURY W	ORK? YES 2 NO	200. 020	,0111021101111				
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, ferm, streething the suiciding, etc. (Specify)					atreet, fectory, off	reet, fectory, office 281. LOCATION (Street City or Town, State				and Number or Rural Route Number,		
290. CERTIFIER		CIAN: To the best of	my knowledge	death sear-	ad at the time de	e and place, and di	a to the co-	use(e) and were	ner ee eleted			
(Check only											end menner ee stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER						200: EIGENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)		
30. NAME AND ADDRESS O						ATTENITIE	EX	CHON	MD	216	0.1	
STEPHEN P 31. DATE FILEO (Month, Day,	CARI	32. REGISTRA	R'S SIGNATURE	E_	TEMITIN	AVENUE	, EA	MIOTON,	raD .	C T ()	0.1	
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30. NAME AND ADDRESS

31. DATE FILED (Month, Day

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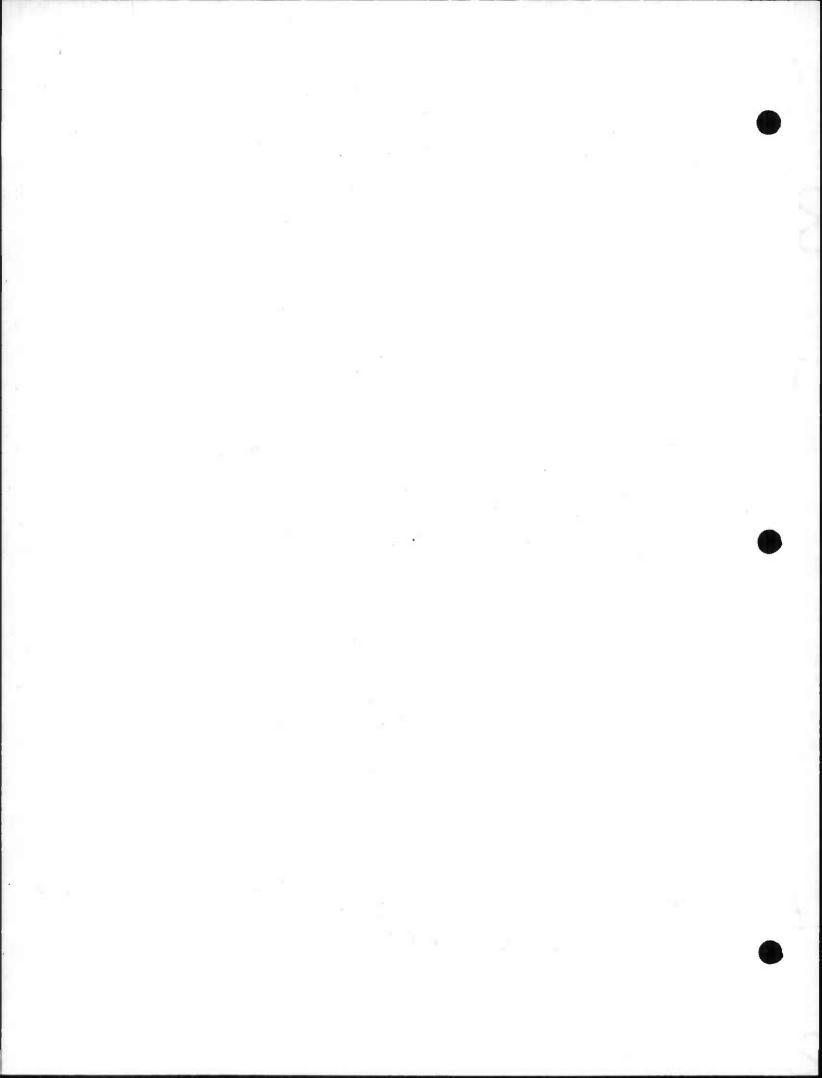
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the standing physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permode filed within 72 hours after death with the State Legic. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTAMT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	6 may be retained by the hospital or attend
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First Middle Last 2. DATE OF DEATH 3. TIME OF DEATH OCT SINCLAIR 23 1995 9:00 A M Gertrude 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. RIRTHPLACE (State or Forming 214-07-8884 127571918 HOURS VAN. 1 M 2 X X 76 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Wesleyan Health Care Center Caroline Denton 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION Federalsburg 10d. INSIDE CITY Caroline MD. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Reliance Road 21632 USA 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 YHO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married White 1 YES 2 NO Specify BY Specify: 3 Wildowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Housewife 0 Housewife 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) Ona May Taylor BE Lee Hurley 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 224 Maple Avenue, Federalsburg, MD. Yvonne J. Statum 21632 20a. METHOD OF DISPOSITION
1 🔀 Burtal 2 🗆 Cremation 3 🗆 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 29c. LOCATION - City or Town, State Dorchester Memorial 10/26/95 Cambridge, MD. 4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Williamson Funeral Home D+100 Federalsburg, MD. 21632 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata ehock, or heart feilure. Llat only one cause on each line Intervei Between IMMEDIATE CAUSE (Finei Onsat and Desth disease or condition Meummin week resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 1 Inpatient 2 ER/Ouipetient 3 DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO В 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be ETED 4 Homicide detarmined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) CERTIFIER 29c. LICENSE NUMBER BE

P. Dorato Drive

ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32, REGISTRAR'S SIGNATURE Talia Davolson Rardall



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A J Br/1, No
31. DATE FILED (Month, Day, Year)
NOV 0 9 1995

955 Fre derick 22, registrar's signature

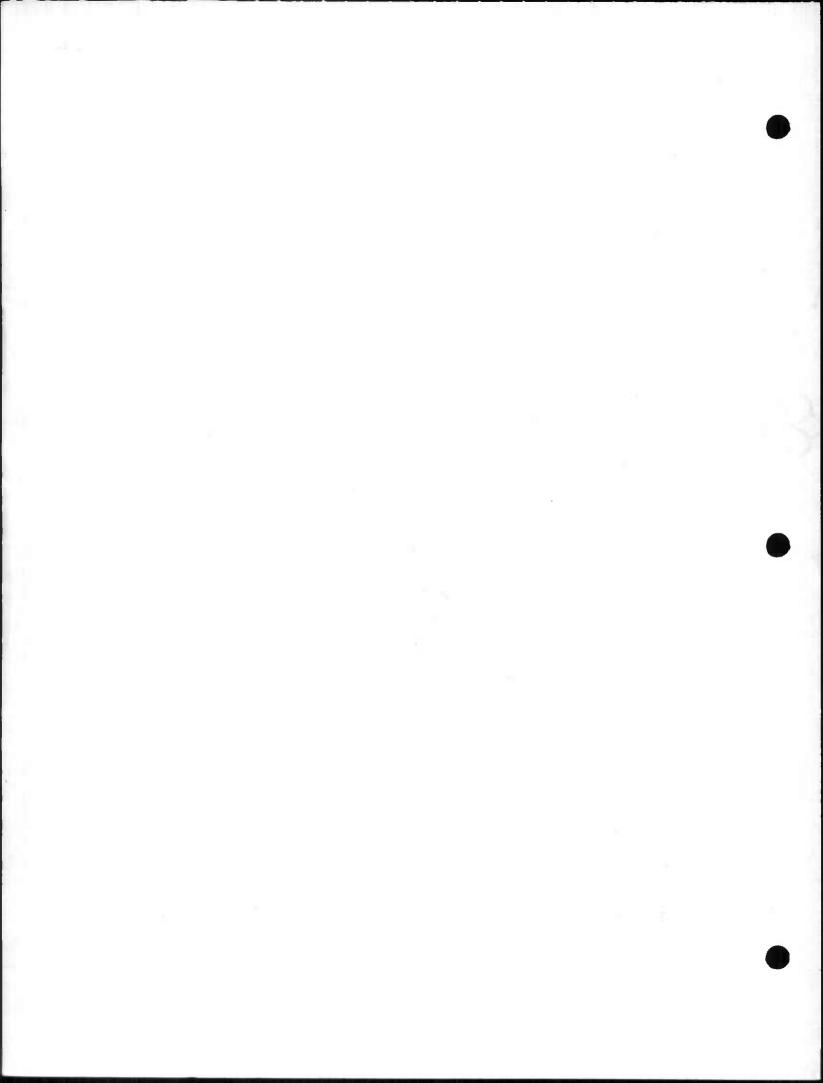
							90	24000	
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		RTMENT OF H		MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. OATE OF DEATH		3. TIME OF DEATH	
	RUBY ELATNE SWA	LIGER				Nov 8,	"1995 ["]	6:20 A M	
	the state of the s	SEX 6. AGE (In yrs. Is	ast birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6.	BIRTHPLACE (State or Foreign Country)	
	412-03-9676	□ M ² □ X 78	YRS.	MONTHS DATE	HOURS WIN,		1917	Ark	
_	9e. FACILITY NAME (If not institution, give street		9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUNTY			
5	DEVIIN MANOR NURS	SING HOME		CUMBE	RLAND		ALL	EGANY	
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	TY, TOWN OR LOCA	TION			10d, INSIDE CITY	
5	MD Älle	ranv		umberlan	b			1 DYES 2 NO	
AL	10e. STREET AND NUMBER	3-1-1			1. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	638 Favotto Stro	2 +			21502		USA		
ا يَ		. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2		13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yee in, Puerto Ricen, etc.)	or No— 14.	RACE — American Indian, Black, White, etc.	
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	X		2 No Specif			Specify:	
9	15. DECEDENT'S EQUICATI	ION 16a F	ECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BUS	INESS (INDITIS)	white	
ETE	(Specify only highest grade con	noleted) /	Give kind of te. Do NOT u	work done during me	ost of working	IND. KIND OF BOS	JINESS/INDOS	# E	
2	1 ')	conege (1-4 or 5+)	Reti	rod		Tire	Compa	ทง	
COMPL	17. FATHER'S NAME (First, Middle, Last)		IVE L		16. MOTHER'S NA	ME (First, Middle, Maiden		TIV	
ш	Andrew K Dunn	1			Cora	Ripley (F	Raker)		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street		Route Number, City or Town		de)	
F	Elizabeth A. Bru		612	Shriver	Avenue: (Cumberland	, MD	21502	
	20e. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Remova	I from State 20b. PLACI	E AND DATE	OF DISPOSITION (Nather place)	ame of			or Town, State	
	4 Donetion 5 Other (Specify)	Sur		Memorial			umberl	and, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	1			ND ADDRESS OF FA	uneral Home	_		
	James to	carpell	1	Cumi	berland,	MD 21502			
	23. PART I. Enter the disease, or com-	plications that coused the c	death. Do	not enter the mo	ode of dying, suc	h as cardlec or reapi	ratory arrest	, Approximate interval Between	
	IMMEDIATE CAUSE (Final	1			•			Onset and Death	
	disease or condition resulting in death) a	Myou	nd	il info	net			emodere	
		DUE TO (OR ME A CONS		2.5%					
o N	Sequentially list conditions, b.	DUE TO (OR AS A CONS	EQUENCE O					32 76 m	
¥	if any, lesding to immediata cause. Enter UNDERLYING	atte	and-	of today				32 m 6 m	
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONS	EQUENCE (OF):				To ma	
ERTIFICATION	resulting in deeth) LAST	(Lype	lym	bones				404	
C	PART il. Other significant conditions of	ontributing to death but not	rasuiting	in the undarlyin	g cause given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
MEDICAL	-	wholites	16	es a luc	- line	PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
				10		1 🗀 YES 2	NO NO	OF DEATH?	
	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF DE	ATH Y	ES NO E	UNCERTAI	N D		1 TES 2 NO	
NA I	25. WAS CASE REFERRED TO MEDICAL			ATH (Check only one,					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 28. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO OTHER: 1 Inpettent 2 EX/Outpettent 3 DOA 4 NOTHER: 27. MANNER OF DEATH 28. DATE OF INJURY 28b. TIME OF INJURY NORK? 28. PLACE OF DEATH (Check only one) THOSPITAL: 1 Inpettent 2 EX/Outpettent 3 DOA 4 NOTHER: 28. DATE OF INJURY 28b. TIME OF INJURY AT NORK?									
黃	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TII		JURY AT ORK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED	
BY	1 Netteral 5 Pending 2 Accident Investigation				YES 2 NO				
ED	3 Suicide 6 Could not be	28e. PLACE OF INJURY — At building, etc. (Specify)	home, term,	street, factory, offic	De	281. LOCATION (Street of City or Town, State)		Rural Route Number,	
	4 Homicide determined								
P		N: To the best of my knowledge,	death occur	red at the time, date	e and place, end due	to the ceuse(e) end man	nner ee stated.		
COMPL	one) 2 MEDICAL EXAMINER:	On the besie of exemination end/o	or investigat	ion, in my opinion,	death occured at the	time, date end place, en	nd due to the c	euse(e) and manner ee stated.	
ш	29b. SIGNATURE AND TITLE OF CENTIFIER	7 .			29c. LICENSE NU	MBER	29d. DATE S	IGNED (Month, Day, Year)	
B	4/200	no ho			10175	65	11/	18185	

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

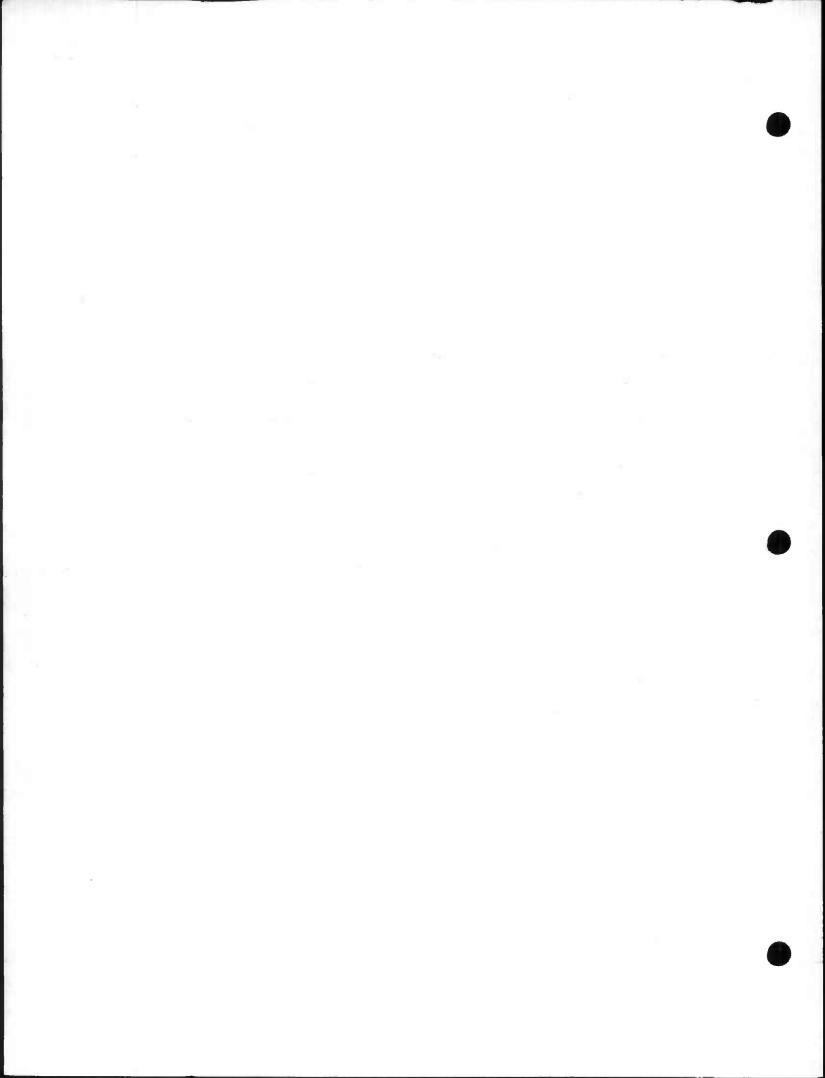
Kamnidis 31. DATE FILED (Month, Day, Year) NOV 03 1995

32. REGISTRAR'S SIGNATURE

											9	5	34863
	1 - FOR STATE REGISTRAR	STATE OF M	IARYLAND /				EALTH /			GIENI	E		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DE	ATH		-	3. TIME OF DEATH
	C.	Ethe1	Lee Tri	mb1e					Nov 2	199	5	YEAR	6:30am M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER	1 YEAR	IF UNDER 2	4 HRS.	7. DATE OF BIF		_	6. BIRT	THPLACE (State or Foreign
	198-30-8679	1 M 2 X F	90	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Aug 12	Year)	15	Coun	ntry)
	9a. FACILITY NAME (If not institution, give st	reet and number)			9h CITY	TOWN C	R LOCATIO	N OF DE		190		NTY OF	ryland
Œ	Brevin Nursing H	,					de Gr		Aun				
5	RESIDENCE OF DECEDENT	Olife			па	vre	de Gr	ace			на	rfor	.d
E I	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY
DIRECTOR	MD Ha:	rford		Hav	re de	e Gr	ace						LIMITS?
	10e. STREET AND NUMBER					101	ZIP CODE				10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	421 S. Union Ave					2	1078				USA		
Ž	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13			HISDAN	IIC ORIGIN? (Spe	olfu Van			CE — American Indian.
	1 Never Married 2 Married		YES 2 X			If yes, sp	cify Cuban,	, Maxicai	n, Puarto Rican,	etc.)	01 110-	Ble	ck, White, etc.
Β¥	3 XWidowed 4 Divorced	IF YES, GIVE W	AN ON DATES			1 U YES	2 X NO	Specify	"			whi	te
G	15. DECEDENT'S EDUC	CATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	N -		16b. KIND	OF BUS	INESS/IN	<u> </u>	
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +	life.	ive kind of Do NOT u	work done is retired.)	during mo	st of working						
7		unknown		mema	ker				Но	me			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	FR'S NAI	ME (First, Middle,	Meirlen	Sumamo)		
	William Creswe	11					Anna			Welder	Our maine)		
BE	19a, INFORMANT'S NAME (Type/Print)		101	MAILIM	ADDRESS	2 /Ctmat a			Route Number, City	a. Taur	- Ctata 2	a Codel	
2	Richard Trimble								osit MD				
	20a METHOD OF DISPOSITION							Бер					
	1 🖾 Burial 2 🗆 Cremation 3 🗆 Rame	oval from State	20b. PLACE A cemetery, cre Brook	metory or a	of DISPOS other place)	ITION (Na	me or		DATE				Town, State
	4 Donation 5 Other (Specify)	ENGER A	БГООК	VIEW			D ADDRESS			KIS	ing	Sun	MD
	21. SERVICE DO	ENSEE	1	1	R	. T.	Foar	d F	uneral	Hom	e. P	A	
	Kuchard	-7.	100	die.					St., Ri		-		21911
	23. PART I. Enter the diseases, or o	omplications the	Caused the de	um. Do	not enter	the mo	de of dyin	g, sucl	h ss cardiac o	r respi	ratory ar	rest,	Approximate
	shock, or hasrt failure.	List only one cau	se on each line	1									intarval Between Onset and Death
	iMMEDIATE CAUSE (Final disesse or condition	5	EDIC	liu	1.0								3 claws
	resulting in death)	DUE TO	OR AS A CONSE	DUENCE O	IFI:								
		mul	Tole	Dr	cul	Centr							12 Man 115
CERTIFICATION	Sequentially list conditions,	b	OR AS A CONSEC										- 1000
TA!	if any, leading to immediate cause. Enter UNDERLYING				,								
윤	CAUSE (Disease Dr Injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE C	IF);								
E	resulting in desth) LAST												
CE									-				
A	PART II. Other significant condition	s contributing to	desth but not r	eauiting	in the ur	deriying	g csuse gi	iven in		WAS AN	AUTOPSY	24	Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
2	old age.	41>CVD							1	YES 2			COMPLETION OF CAUSE OF DEATH?
AEI I	0										4		1 YES 2 NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH Y	ES 🗍	NO IX	LUNCE	RTAIN	v 🗆			- 1	, , , , , , , , , , , , , , , , , , , ,
¥	25. WAS CASE REFERRED TO MEDICAL				TH (Check	,							
22	EXAMINER? 1 YES 2 NO	HOSPITAL:	ED/Outpetlant 2	□ DO4	OTHE								
<u>¥</u>	27. MANNER OF DEATH	28a. DATE OF		28b. Till	-	28c. /NJ		Hoenca	6 Other (Spec		M ILIBY OC	∨~inen	
	1 Natural 5 Pending	(Month, D			JURY	WO	RK?	NO.	200. DESCRIBE	. HOW II	NJORT OC	CONED	
B	2 Accident Investigation	28a PLACE O	F INJURY — At ho	me term	street feet				284 LOCATION	100	and Moranha	0	I Control Number
8	3 Suicide 6 Could not be 4 Homicide datarmined	building,	etc. (Specify)	rries, carries,	atingt, taci	iory, ornic			281. LOCATION City or Town	n, State)	ina Nymbe	er or Hunei	Houte Number,
ᆸ	200 CERTIFIER												
P.	29a. CERTIFIER (Check only one)												
COMPLET	2 MEDICAL EXAMINE	R: On the beals of a	camination and/or	Investigati	on, in my o	opinion, d	aith occure	d at the	time, data and p	lece, en	d due to t	the cause	e(a) and manner as stated,
ш	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICEN				29d. DA	TE SIGNE	ED (Month, Day, Year)
00	Whinan	MD					D	32	609				las
임	30 NAME AND ADDRESS OF PERSON WH	O COMBI ETED ONLY	OF OF DEATH ATE	M 077 /T	0.1.0			_				\rightarrow	

DHMH-16 Rev 1/89

. Havre De Grau ms 2107



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING

TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 has IMPORTANT: If IN

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	hould be detached for use as the burial-transit permit. Pages 1.		
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SH	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sh	with	Hem 28 is marked, or Hem 23 shows any injury, or other traumatic event, the medical examiner r
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PHYSICIAN: MEDICAL

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH John Tayman Leonard 11:25 P 1995 November 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign oct. 29,1927 215-20-3513 Maryland 1 X M 2 - F 68 VRS 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Physician Memorial Hospital LaPlata Charles RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Charles Maryland Port Tobacco 1 YES 24 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 7606 Simms Landing Road 20677 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 HO Specify: Specify: 3 Widowed 4 Divorced 1946 Caucasian 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) tary/Secondary (0-12) College (1-4 or 5+) N/A 12th Produce Manager Safeway 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Clarence Walter Tayman Mary Myrtle Dement 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Tayman 7606 Simms Landing Road Port Tobacco Md 20677 20a. METHOD OF DISPOSITION
1 X Burlei 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of NOV carefery, crematory are their place) in Garden's 20c. LOCATION - City or Town, State DATE ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 21. SIGNATURE OF FUNERAL SE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 23. PART V Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20 /Approximate shock, or heert failure. List only one cause on sech line. Interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death disease or condition Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF): reaulting in deeth) Generalized Atherosclerosis Sequentially lifet conditions, If any, leeding to immediate e. Enter UNDERLYING Benign Essential Hypertension CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST Diabetes Mellitus

PART ii. Other significent condition	a contributing to deeth but not r	Part I.	24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
Post Abdominal	PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE					
Post Common and Pancreatic Duct Stenosis						OF DEATH?	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TO UNCERTAIN N							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATN (Check only one) HOSPITAL: 1 Inpetient 2 SER/Outpetient 3 DOA 4 Nursing Nome 5 Residence 6 Ott					er (Specify)		
27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW INJURY OCCURED			
3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				OCATION (Street and Number or Rural Route Number, ity or Town, State)		
29a. CERTIFIER (Check only 1 KDERTIFYING PNYS)	CIAN: To the best of my knowledge, de	ath occurred at the	time, date and place, and due t	o the car	use(a) and manner as stated.		

n and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

D07287 30 NAME AND ADDRESS OF PERSON WHO COMPLETED SAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. R.A. McConnaughy 11418 Livingston Road, Fort Washington, Maryland 20744 31. DATE FILED (Month, Day, Year)
NOV 0 7

32. REGISTRAN & SIGNATURE PARKALL

2 MEDICAL EXAMINER: On the be

TITLE OF CERTIFIER

29d. DATE SIGNED (Month, Day, Year)

TO BE COMPLETED BY FUNERAL DIRECTOR

34865 95

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATN			
WILLIAM	G.	TH	EARNEY	OCTOBER 2	71. 199	6:40A M			
4. SOCIAL SECURITY NUMBER		MON	INDER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR Cou	THPLACE (State or Foreign			
218-90-8240	1 <u>√√</u> M 2 ☐ F	31 YRS.		6-28-64	Wa	shington DC			
9e. FACILITY NAME (If not institution, give	•		CITY, TOWN OR LOCATION OF L		9c, COUNTY OF				
ONE BLOCK NOF		HAMPSHIRE	& PINEY BE	RANCH RD	PRINCE	EGEORGES			
MD Monto	gomery		wn on Location hersburg			10d. INSIDE CITY LIMITS?			
10e. STREET AND NUMBER	50MCL y	Gait	101. ZIP CODE			1X YES 2 NO			
	est Court		20877		1117	SA			
11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF HISP/ If yea, specify Cuben, Mexic		or No- 14. RA	CE American Indian,			
1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 ☐ YES 2 NO Spec		Spi	ecify:			
15. DECEDENT'S ED	JCATION	16a. DECEDENT'S USU	AL OCCUPATION	16h KIND OF BUS	I B	lack			
(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of work of life. Do NOT use reti	done during most of working	Tool Kill of Box	311/233/11/3031111				
	2½ vears	Mainte	nance	Chestn	ut Iod	re Hospital			
17. FATHER'S NAME (First, Middle, Lest)				IAME (First, Middle, Meiden		3,5 1113,1114			
Russell J. Te	earney		Kath	erine Smit	h				
19e. INFORMANT'S NAME (Type/Print)			PRESS (Street and Number or Rura						
Dr. & Mrs. Russe				ilver Sprin					
N	noval trom State cen	netery, cremetory or other p	(ace)	3	CATION — City or				
21. SIGNATURE OF FUNERAL SERVICE L		Gate of He	aven Cemetery 22. NAME AND ADDRESS OF F	LU-28 Si	Lyer Sp L's Fun	eral Home Inc			
+ + P mas	18,00					eet, N. W., . C. 20011			
23. PART I. Enter the disesses, or	complications that cause	d the deeth. Do not e	enter the mode of dying, su			Approximate			
shock, or heart failure	List Dnly Dne ceuse Dn e	ech line.	, , ,) f	1	intervel Between Onset and Death			
iMMEDIATE CAUSE (Finei disease or condition resulting in death)	. May	ple thy	wies Cen	prated	bu	Onsat and Doath			
The second of the second	DUE TO (OR AS	ONSEQUENCE OF):	1	V	1				
Sequentielly list conditions,	DUE TO (OR AS	JUUNA	JI NG						
if eny, leeding to immediate cause. Enter UNDERLYING	DOE TO (OH AS)	CONSECUENCE OF):	5						
CAUSE (Disease or Injury that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):							
resulting in deeth) LAST	d								
PART II. Other eignificent condition	ne contribution to death b	nut not reculting in th	an underlying acuse alves i	n Pert I. 24a, WAS AN	AUTODOV L	AL MEDI MITTER VICENCE			
TAIT II. Other eighticent condition	obital butting to death t	out not resulting in the	ie underlying cause given i	PERFO	PMED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE			
				1 YES 2	! □ NO	OF DEATH?			
DID TOBACCO USE CON	TRIBUTE TO CAUSE O	OF DEATH YES	□ NO 🕱 UNCERTA	IN D		YES 2 NO			
25. WAS CASE REFERRED TO MEDICAL	1 0,1002	28. PLACE OF DEATH (C							
EXAMINER? 1 X YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out		HER: Nursing Home 5 - Residence	8 X Other (Specify)	WOODED	AREA			
27. MANNER OF DEATN	28e. DATE OF INJURY / (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE NOW		SA A			
1 Netural 5 Pending 2 Accident Investigation	10/21/9	5 UNK	M 1 TES 2 NO	Bizychist	IN DO	cident			
Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spe	— At home, farm, street	t, fectory, office	281. LOCATION (Street City or Town, State)	end Number or Rurs	A Route Number A Aof OL			
4 Nomicide determined		SILLER	31	New 40	repstire	five, mo			
maked the same of the same of			the time, date end place, and de						
		m end/or investigation, in	my opinion, death occured at the	he time, date end place, er	nd due to the ceus	e(e) end menner as stated.			
246 AIGHATURE AND TITLE OF CERTIF	Tela IM	\wedge	29c. LICENSE N			ED (Month, Day, Year)			
TA HAME DITCHESS OF PERSON W	NO COMPLETED CAUSE OF DE	<u></u>		.M.E. 0	CTOBER	21, 1995			
FLA LON CO	CKE, MD		Street, B	altimore,	Maryla	and 21201			
31. DATE FUED (Manth, Day, Year) 31 1995	THE CHARGE	Charlett							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

91.148.51.55

BALTIMORE, MARYLAND 21215-0020	ter death. Page 6 may be retained by the hospital or attending physicia
BALT	24 hours after death. F
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3760	cuted with
.O. BOX 6	certificate be executed within 24 hours after
, P.O. BOX 68	eath certificate be exe
RECORDS, P.O. BOX 68	w requires that the death certificate be exe
AL RECORDS, P.O. BOX 68	e law requires that the death certificate be exe
TAL RECORDS, P.O. BOX 60	The law requires that the death certificate be exe
VITAL RECORDS, P.O. BOX 6	4N; The law requires that the death certificate be exe
OF VITAL RECORDS, P.O. BOX 6	PHYSICIAN; The law requires that the death certificate be exe
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ISION OF VITAL RECORDS, P.O. BOX 6	TTENDING PHYSICIAN; The law requires that the death certificate be exe
DIVISION OF VITAL RECORDS, P.O. BOX 68760	A ATTENDING PHYSICIAN: The law requires that the death certificate be exe

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	A ==== T			2. DATE OF DEATH MONTH D	AV V	3. TIME OF DEATH
	HES-		AYLOR		Dotober	28 1	995 10:15 ^P
	4. SOCIAL SECURITY NUMBER 212-16-5455	1 M 2 XF 81		UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 6/16/14		BIRTHPLACE (State or Foreign Country) aryland
-	9a. FACILITY NAME (If not institution, give s			. CITY, TOWN OR LOCATION OF I	HAB	9c. COUNTY	
DIRECTOR	Southern Maryla RESIDENCE OF DECEDENT 100. STATE 100. COUNT			Clinton		Princ	ce Georges
	Maryland Princ	ce George		own on Location Washington			10d. INSIDE CITY LIMITS? 1 A YES 2 NO
FUNERAL	38 Pates Dr.			101. ZIP CODE 20744		10g. CITIZEN	N OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3. Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	13. WAS DECENDENT OF HISP/ If yes, specify, Cuben, Mexic 1 YES 2 NO Speci	an, Puerto Ricen, etc.)	s or No- 14.	. RACE — American Indian, Black, White, etc. Specify: White
9	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S USE	JAL OCCUPATION done during most of working	16b, KIND OF BU	SINESS/INDUS	TRY
COMPLETED	Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	Homemake:	tired.)	at hor	me	
S S	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Maiden		
BE	Samuel D. Pickrel	L		Annie	Irene Pick	re1	
10	190. INFORMANT'S NAME (Type/Print) Wayne Taylor			press (Street and Number or Rura.			
	29a_METHOD OF DISPOSITION 1.4_Burlet 2 Cremetton 3 Rem 4 Donetton 8 Other (Specify)	oval from State	.PLACE AND DATE OF D		DATE 20c. LO	CATION — City	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	don'ing con	George P. Kal	ACILITY_	LLIand,	, 1 ⁴ C .
CYB	har P. K	den .		6160 Oxon Hil	1 Rd. Oxon	Hill,	Md. 20745
	23. And I. Enter the disease, or ahock, or heert fellure. IMMEDIATE CAUSE (Final	complications that caused List only one cause on a	the death. Do not ach line.	enter the mode of dying, au	ch ae cerdiac or reep	iratory erreat	Approximata Interval Between Onset and Death
1	disease or condition resulting in deathj	. ASPIRA	ATTON CONSEQUENCE OF:	PNEUM	MIA		Onset and Death
NC	Sequentially list conditions,	SIPLA	MINE	cromy			
ATI	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):	,			
CERTIFICATION	CAUSE (Diseese or Injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF):				
EH	resulting In death) LAST	d					
A	PART II. Other eignificant condition	e contributing to death b	ut not regulting in t	he underlying ceuse given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDIC					1 🗍 YES 2	X'NO	COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	E DEATH YES	□ NO □ UNCERTA	N []		1 - YES 2 - NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH				
VSIC	1 YES 2 XNO	HOSPITAL: 1 D Inpatient 2 - ER/Outp		THER: ☐ Nursing Home 5 ☐ Residence	8 Other (Specify)		
	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WORK?	28d. DESCRIBE HOW	NJURY OCCUR	ED
B	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, ferm, stree	M 1 YES 2 NO	281. LOCATION (Street	and Number or i	Rural Routa Number
ETED	4 Homicide determined	building, etc. (Spec	offy)		City or Town, State)		
COMPLET				t the time, date end place, end du n my opinion, death occured at th			suse(e) and manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIED	1 \$10	,	29c. LICENSE NU	MBER	29d. DATE SI	IGNED (Month, Day, Year)
TO B		gars 1	Physici	an) D46	478	10	-29-90
	S. Patel 750	SURRATT			INTON,	mp	20735
	31. DATE FILES (MODIF), DBY, YORY) (1995)	32 AGGISTARE'S SIGN	or harlatt				

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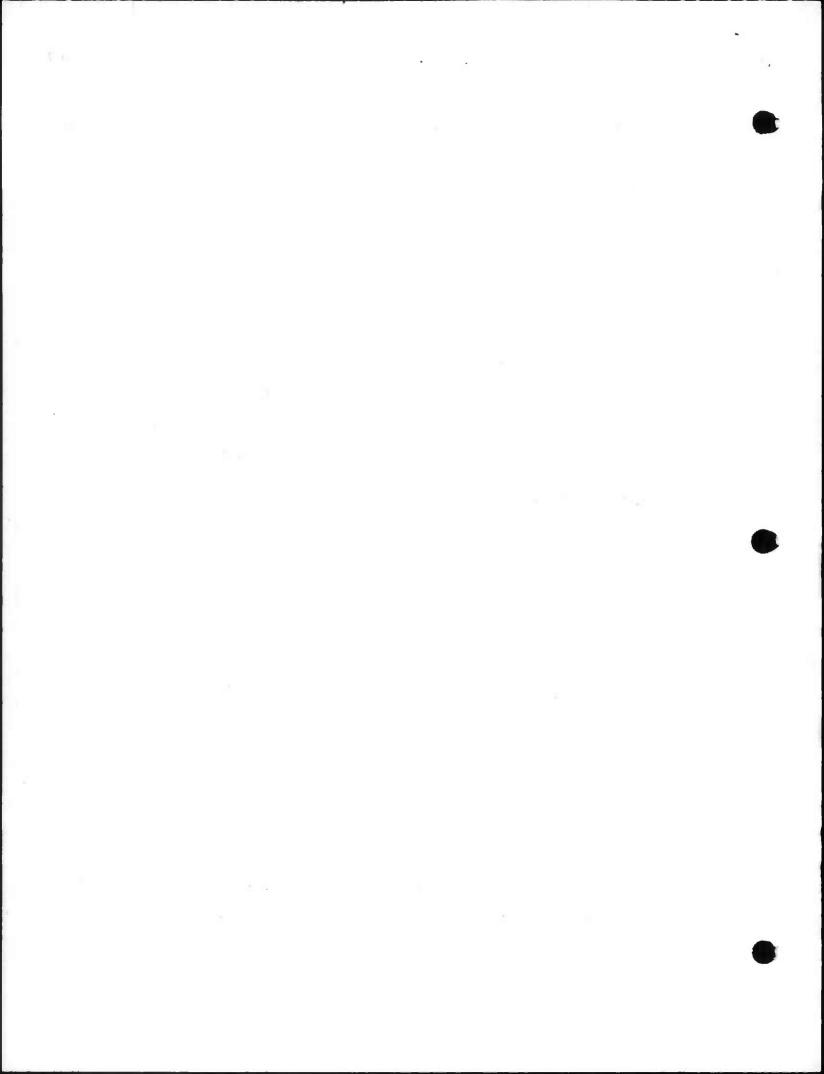
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flore death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MEN	TAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG, NO.										
	1. DECEDENT'S NAME (First, Middle, Last HENRIETTA	Townsend TIMMON	NS		_	2. DATE OF DEATH NOVEMBER	Ď4, 199	3. TIME OF DEATH 5 1:59 P			
	4. SOCIAL SECURITY NUMBER	1 1	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)				
	219-36-7389 9a. FACILITY NAME (If not institution, give		9 YRS.	MONTHS DAYS	HOURS MIN.	9/26/06		MD			
æ	Berlin Nursing			96. CITY, TOWN O	R LOCATION OF OR	EATH	9c. COUNTY O				
כוכו	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT						WOI CE				
DIRECTOR		cester		y, town on locat cean Cit			10d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER	CCSTCI			ZIP CODE		10g. CITIZEN C	1 🔀 YES 2 🗌 NO			
FUNERAL	100 Talbot St.				21842		US	SA			
F	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER IF FORCES? 1 YES	2X NO	II yes, spe	cify Cuban, Maxica	HC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	or No- 14, R	ACE — American Indian, lack, White, atc.			
ВУ	3 🗶 Widowed 4 🗋 Divorced	IF YES, GIVE WAR OR D	ATES	1 🗆 YES	2 NO Specify	C	S	white			
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S	USUAL OCCUPATION work done during most retired.)	IN st of working	16b. KIND OF BUS	INESS/INDUSTR	Y			
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Teach			Educ	ation				
O	17. FATHER'S NAME (First, Middle, Last)		7 64 611		18. MOTHER'S NA	ME (First, Middle, Malden					
BE (Ephriam Wilson	Townsend				Cropper					
5	19a. INFORMANT'S NAME (Type/Print) Sally Parker					sbury, MD					
	20a. METHOD OF DISPOSITION	200		OF DISPOSITION (Na			2180 CATION — City of				
	1 X Burial 2 Cremation 3 Rer 4 Donetion 5 Other (Specify)		Evergree	en Cemet	ery 1		rlin, M				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home										
Щ	108 Williams st. Berlin, MD 21811 23. PAHT LEnter the diseases, for complications that caused tha death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate										
	23. PAHT I. Enter the dispases, for shock, or heert fellure. IMMEDIATE CAUSE (Finel disease or condition	complications that caused. List only on cause on e	tha death. Do i	not enter the mod	de of dying, suc	h as cerdiac or respi	ratory arrest,	Approximata interval Between Onset and Death			
	resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF):										
z	Sequentielly list conditions, b. ASSID.										
CERTIFICATION	if sny, leeding to immediate cause. Enter UNDERLYING	DEE TO (OR AS A	CONSEQUENCE O	F):							
FIC	CAUSE (Diseese or injury that initieted events	C. DUE TO (OR AS A	CONSEQUENCE O	F):				-			
E	resulting in deeth) LAST	d	/								
AL C	PART II. Other significent condition	ns contributing to death b	ut not reculting	In the underlying	ceuse given in			24b. WERE AUTOPSY FINDINGS			
MEDIC	- Rihy	dulm				PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?			
ME	to tal	1 Cine						1 TYES 2 X NO			
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YE		UNCERTAIN	<u> </u>					
SIC	EXAMINER? 1 TYES 2 X NO	HOSPITAL: 1 Inpetient 2 ER/Outp			5 Residence	8 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM		JRY AT	28d. DESCRIBE HOW IN	JURY OCCURED				
BY	1 X Natural 5 Pending 2 Accident Investigation	OR- DI AGE OF MUNICIPAL		M 1 🗆 Y	ES 2 NO						
ETED	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, etc. (Spec	— At nome, farm, :	etree1, factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or Rui	ral Route Number,			
APLE		SICIAN: To the best of my knowl									
COMPL	2 MEDICAL EXAMIN	ER: On the basis of examination	and/or investigation	n, in my opinion, de			due to the ceus	se(a) and manner as stated.			
B	29b. SIGNATURE AND TITLE OF CERTIFIE	in 2-2-2-2-			29c. LICENSE NUM		29d. DATE SIGN	RED (Month, Day, Year)			
안	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	D0202	U	- //	191			
	FEDERICO G. ARTH		A OCEAN		ERLIN, M	D. 21811	410-641	-6363			
11	31. DATE FILED MOON ON YOU 199	32. REGISTRAR'S SIGN	ATURE	4.			**				
	0.0 100		Marson								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_ [1. DECEDENT'S NAME (First, Middle, Last) Bette Anne Taylor 2. Date of Death November 2, 1995 3. Time of Death 5:50 P.M													
													2, 15		5:50 P.M.
		4. SOCIAL SECURITY NUMB		5. SEX	, ,	rs. last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE O	Day, Year)	0.07	Countr	PLACE (State or Foreign
밀		215-34-250		1 🗆 M 2) [] F	58	YRS.					Jan.	1, 1	937		rland
3 should	Œ	Sacred Hea							or Location		ATH			NTY OF D	
1, 2,	유	RESIDENCE OF DEC		эртоаж				ano c	71 200110					-060	
	DIRECTOR	10e. STATE	10b. COUNTY			10c. CI	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?
permit. Pages	100	Maryland	Alle	gany		0	resal								1 X YES 2 NO
	RAL	10e. STREET AND NUMBER						10	of. ZIP COD						VHAT COUNTRY?
an. Iransi	NER	14200 ELte	n Dri	12. WAS DECEDEN		U.S. ARMED 13. WAS DECEMBENT OF HISPAN					U.S.A.				
020 physician. burial-transit	FUN	1 Never Married 2	Married	FORCES? 1	YES 2	ANO		if yes, s	pecify Cuba	ın, Mexica	n, Puerto Ri		or No —	Black	E — American Indian, c, White, atc.
21215-0020 al or attending physician. for use as the burla-trar	B	3 Widowed 4 N Divo	rced	IF YES, GIVE V	MAN ON DATE	R OR DATES 1 TYES 2 NO Specify:							Speci	White	
215 attend	ED		EDENT'\$ EDU		18	a. DECEDENT'	S USUAL O	CCUPAT	TION nost of working	na	16b.	KIND OF BU	SINESS/INC	DUSTRY	
21 or at or to		Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NOT	use retired.)						CI.		
LAND 2 the hospital detached to once.	COMPL	12				Clerk			_			rocer	-	re	
the hos detach	8	17. FATHER'S NAME (First, Mi							-			iddle, Maiden	Surname)		
RYL ed by uld be	BE	Paul La F				Lantonia		0.40	_		ne Fe		0	0.41	
MARYLAND retained by the hospit should be detached notified at once.	2	Mark J. Ta										er, City or Tow			22120
E, De page		20. METHOD OF DISPOSIT	ION		20h PI	ACE AND DAT	_	_		ane,	DATE		CATION -		a. 73120
BALTIMORE, after death. Page 6 may be you the funeral director, page moval.		1 Burial 2 Cremation 4 Demation 8 Other	n 3 🗆 Ram	oval from State		ry, prematory or Stourg	other place	ria	1 Par	rk	11/	6 Fr	ostbu	irg,	Maryland
Page al dire		21. SIGNATURE OF FUNERAL	L SERVICE LI	CENSEE	8		22.	NAME /	AND ADDRE	SS OF FA	CILITY 57	Fros	t. Ave		
ALT death funer		1 John	11.7	4orn											Md. 21532
B/ nours after of of in by the or removal.		23. PART i. Enter the di		complications the											Approximats
nod li		ehock, or he IMMEDIATE CAUSE (Fir		List only one ce	use on each	n line.									Onset and Death
		discess or condition													
rted with		DUE TO (OR AS A CONSEQUENCE OF):												Jo years	
C68760 executed with and comple o burial, cre	Z	Sequentielly list conditi	lona	b. C)	nronie	Obstr	ucti	ve_I	Pulmo	nary	Dise	ase			20 years
	CERTIFICATION	if any, leeding to imme- cause, Enter UNDERLY	diete	DUE TO	OR AS A CO	DNSEQUENCE	OF):								
	FIC	CAUSE (Disease or inju		C DUE TO	OR AS A CO	ONSEQUENCE	OF):	-				= 1			
	E	reaulting in death) LAS	т	d											
DS, P the death the atten d Mental !		DAGE II ON a standing	and an annual fall and			and a secondar	1				Dist.			1	
m = 65 -	EDICAL	PART II. Other algnifica			deeth but	not resulting	In the u	nderiyi	ing cause	given in	Part I.	24s. WAS AN PERFOI		240	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
Signed by Health and Health and	ă	Hypert									- 1	1 TYES	X NO		OF DEATH?
	Σ	Polycy DID TOBACCO U			ALISE OF	DE ATU V	/EC FV	NO I		CEDTAI					1 NES 2 NO
23 ep 88 52	AN	25. WAS CASE REFERRED T		KIBUTE TO CA		PLACE OF DE				CERIMI	и Ш				
VISION OF VITAL RE ATENDING PHYSICIAN: The law requ ECTOR. After this certificate has been s after death with the State Dept. of 1 1 28 is marked, or item 23 sho	PHYSICIAN:	EXAMINER? 1 YES 2 YNO		HOSPITAL:	ER/Outpati	ent 3 🗆 DOA	OTHE 4 Nu		ome 5 🗆 R	aaldenca	8 Other	(Specify)			
Sicia certification the	H	27. MANNER OF DEATH		28s. DATE O	F INJURY	28b. T	IME OF	28c, II	NJURY AT			CRIBE HOW	INJURY OC	CURED	
の光温達	ВУ Р	1 Metural 5 2 Accident	Pending Investigation	(MOTRIT, 1	Day, Year)		M		WORK?	_ NO					
NOING R NOING R S. After r death		3 Suicide 8	Could not be		OF INJURY	At homa, farm	, street, fac	tory, off	fice		28f. LOCA	ATION (Street or Town, State	and Numbe	r or Rural	Route Number,
DIVISION OR ATTENDING I DIRECTOR: After hours after death Item 28 Is max	II	4 Homicide	determined												
DIV L OR A DIREC hours	COMPLET	29a. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best of	of my knowled	ge, daeth occu	rred at the	time, de	ite and place	e, and due	to the cau	ee(a) and me	nner se str	rted.	
THE HOSPITAL THE FUNERAL filed within 72 I	OM	one) 2 MED	ICAL EXAMIN	ER: On the baela of	examination a	nd/or investigs	tion, In my	opinion,	, death occu	ared at the	time, data	and placa, a	nd dua to t	tie cause(s) and manner as stated.
THE HOSPI THE FUNER filed within PORTANT:		29h. SIGNATURE AND TITLE	OF GERTIFIE	")^^						ENSE NU			29d. DA	TE SIGNED	(Month, Day, Year)
E SE SE SE SE SE SE SE SE SE SE SE SE SE	3 BE	(Tease		alles	wes-	M			104	0095				11/3	/95
8	2	30. NAME AND ADDRESS O	F PERSON WI	O COMPLETED	ISE OF DEAT	H # EM 27) (7)	pe, Print)		77.0		T **	7-7-	Ma '	21 50	,
n Po				egrino,			latio	nal	High	way,	TS A	ате,	PICI.	6170	G
1000		NOV 06		ALLA WALL	Wish Na	rdall									1
	- 1	110100	1000	[]											

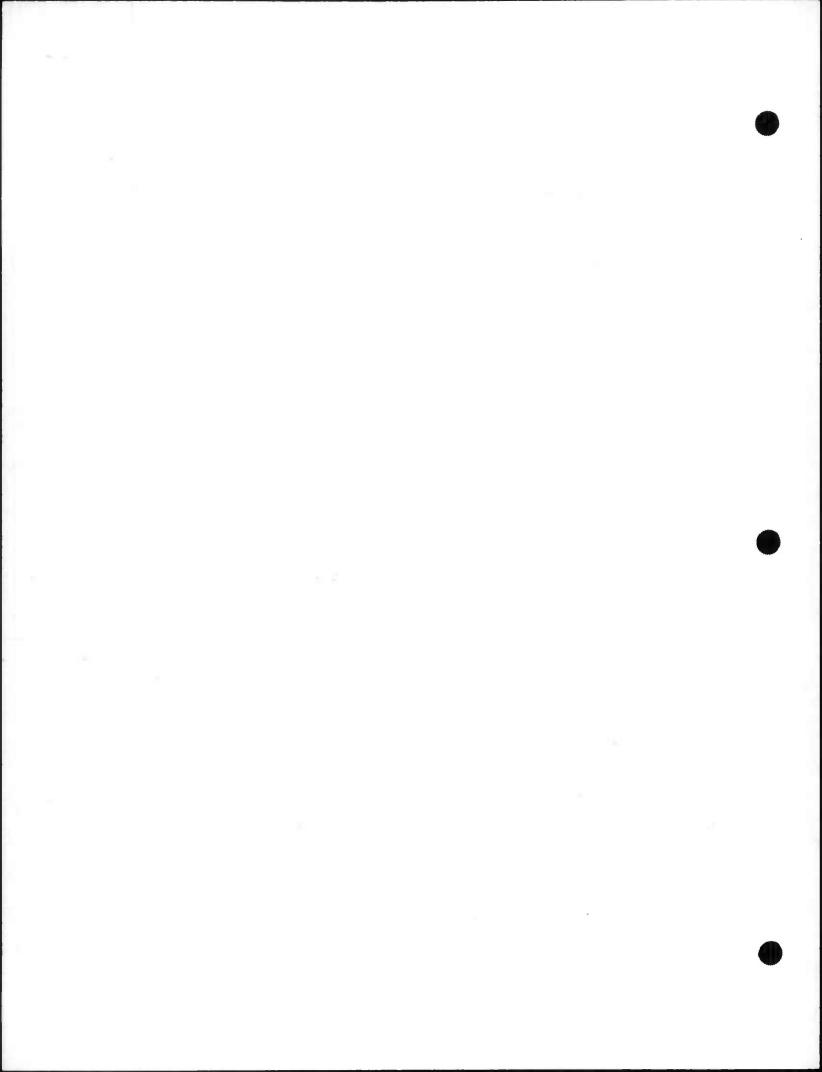
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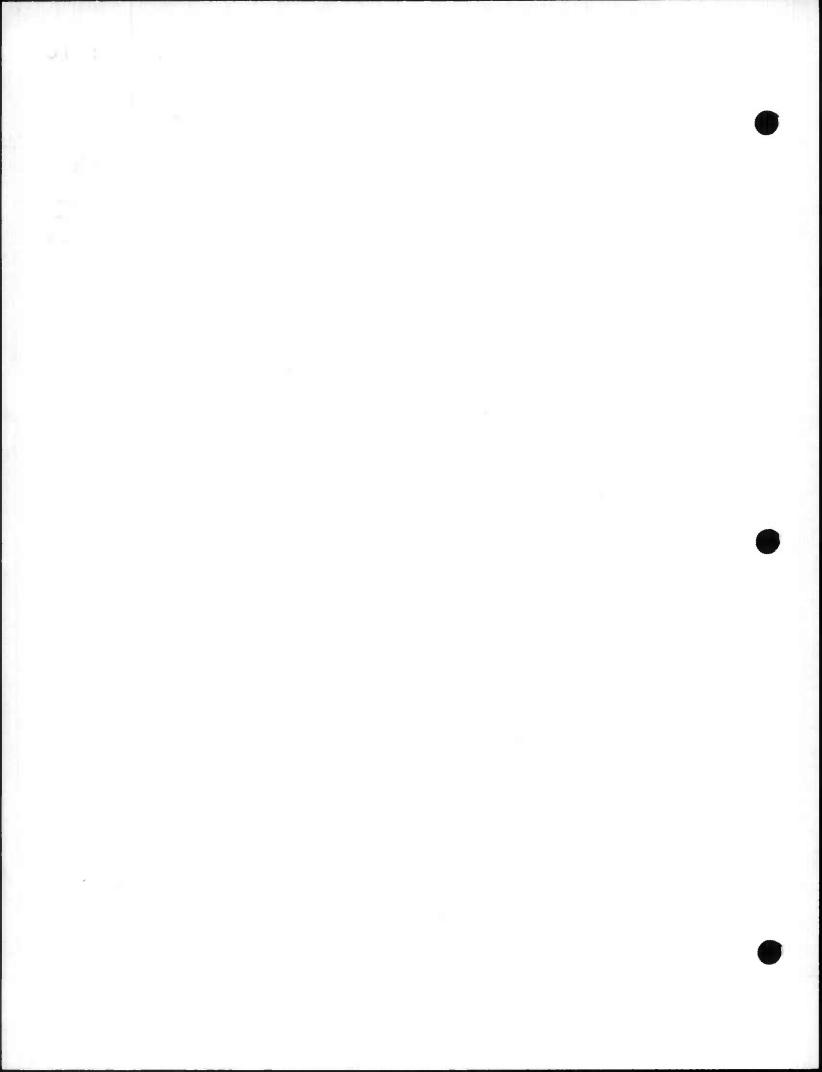
		1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM CERTIFICA	ENT OF H	IEALTH AND	MENTAL	HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE (OF DEATH		YEAR 3.	TIME OF DE	EATH	
			J.	TINSLE			ОСТО	BER 30	199	5 7	:30	Рм	
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	1404	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE O (Month,	Day, Year)		Country)	ACE (State or	Foreign	
pino		232-01-1353 9e. FACILITY NAME (If not institution, give s		90 YRS.	OTTO TOWN (OR LOCATION OF D	<u> </u>	15 1		iary1			
1, 2, 3 should	DIRECTOR	MEMORIAL HOSPITAL			CUMBERI		EATH		ALLE		Н		
ages 1	E E	10a. STATE 10b. COUNT		10c. CITY, TO	WN OR LOCAT	rion				10-	d. INSIDE CI	ITY	
E .			egany	West	ernpor	t				1 (YES 2	□ NO	
it per	FUNERAL	10e. STREET AND NUMBER			101.	f. ZIP CODE			10g. CITIZE	N OF WHA	T COUNTRY	7	
dan. -trans	N.	215 Greene St.	12 WAS DECEDENT EVED IN	" o ansen	42 MM 0 DEC	21562	The management		Unite				
020 physic burial		1 Never Merried 2 Married	FORCES? 1 YES	2 NO	If yes, spi	CENDENT OF HISPAI	an, Puarlo Ri	(Specify Yee ican, atc.)	or No-	Black, W	American in thite, etc.	idlen,	
215-0020 attending physic	BY	3 X Widowed 4 Divorced	n red, dire min on an		I L TES	3 2 NO Specif	у:			Specify:	White	j	
LAND 21215-0020 The hospital or attending physician, detached for use as the burial-transit permit. Pages 1,	표	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DECEDENT'S USUA (Give kind of work of	done during mo:		16b.	KIND OF BUS	SINESS/INDUS				
	무	Elementary/Secondary (0-12) Unknown	College (1-4 or 5+)	Bookeepe	ired.)	-		01					
AND the hospital detached	once. COMPLET	17. FATHER'S NAME (First, Middle, Last)		pookeehei	L	18. MOTHER'S NA			eaning	5			
YL V	111	D .	Loenza Calvin Lambert Nell										
MARYLAND retained by the hospit 5 should be detached	netified TO BE	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Numbe	er, City or Town	n, State, Zip Co	ode)			
2 8	be no	Florence Welsh 206 McKinley St., Westernport, Md. 21											
ORE o may tor, pa	must b	20a. METHOD OF DISPOSITION 1 METHOD 2 Cremation 3 Ram		PLACE AND DATE OF DIS	olace)		DATE	20c. LOC	CATION — Cit	y or Town,	State		
IMC Page 6	E	4 Donation 5 Other (Specify)	-	Philos C	Cemeter	ry 11-		Wes	sternp	ort,	Md.		
BALTIMORE, after death. Page 6 may by by the funeral director, page	examiner	1//1/	n Kol	9		Funeral		1					
		no DADT I Enter the diseases or	Down	_	111 (Church S	t. We	stern	port,	Nid.			
in the	medical		List only one ceuse on eed	the death. DD not e ch line.	nter the mo	de Df dying, auc	h es cerdi	ec Dr reapii	ratory arres	t,		Between	
42 Illi	흎	IMMEDIATE CAUSE (Final disease or condition	. Cardiogenio	Shock								ours	
60 I withi mplete	event,	reaulting in death)		1									
x 6876C executed within n and completely to burial, cremat		Sequentially list conditions, Acute Myocardial Infarction											
or the period	traumatic ATION	If any, leading to immediate											
BOX inficate be physician and prior to	other tr	CAUSE (Disease or injury that initiated events	U	consequence of):	se						10 3	Years	
S, P.O. BC death certificate attending physie ental Hygiene pri	y, or other traumatic	resulting in deeth) LAST	d										
	-	PART II. Other significent condition	es contributing to death bu	et not resulting in th	- underlying	- seuse alven In	Part I	UMCAN	·······································	Total Mile			
2 th	- 45	The state of the s		I not teaming in the	e underlying) Ceuse given in		PERFORI	MED?	AMA	ERE AUTOPSY AILABLE PRIO IMPLETION DI	OR TO	
RECOF requires that een signed to of Health a	shows any : MEDIC						-	1 TYES 2	NO	OF	DEATH?	/	
> 50 40	S sho	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH YES	□ NO V	UNCERTAIL	N I			1 1	YES 2	J NO	
⋖ 9 E □	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	20	6. PLACE OF DEATH (C)	heck only one)								
F VITA SICIAN: The certificate	or ite	1 - YES 2 NO	HOSPITAL: 1 Pinpetient 2 - ER/Outpet		HER: Nursing Home	s 5 🗆 Reeldenca	8 🗆 Other	(Specify)					
VISION OF VI ATTENDING PHYSICIAN: ECTOR: After this certifica s after death with the St	P. Ked,	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WOI	PK?	28d. DESC	RIBE HOW IN	IJURY OCCUR	ED			
ON DING P After t	marked BY PI	2 Accident Investigation	28s. PLACE OF INJURY -	At home form street		YES 2 ND		71011 101					
DIVISION OR ATTENDING R DIRECTOR: After hours after death	28 IS	4 Homicide 8 Could not be	building, atc. (Specif)	y)	, ractory, office		City or	Town, State)	nd Number or	Hurai Houte) Number,		
OR DIRE	itel itel	29e. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of my knowled	doe death occurred at	the time date	and place, and due	to the cour	ofa) and man	nas en elet-el				
₹ ¥ 2	= 5	(Check only one) 2 MEDICAL EXAMINE	R: On the besis of exemination	and/or investigation, in	my opinion, de	eath occured at the	time, data a	and place, and	dua to the c	ause(s) an	d menner as	stated.	
E HOSPI E FUNES d within		29b. SIGNATURE AND TITLE OF CERTIFIE		0		29c. LICENSE NUR			29d. DATE S				
일본 보	IMPOR		8 ISPE	1		D 23334 312 October 197							
4	_ F	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE DF DEAT	TH (ITEM 27) (Type, Print)									
MLX		DINESH SHAH M.D.,			MD 21	556							
72700		NOV 03 1995	JULY DRUMENT A	ardall									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		REGISTRAR		CERTIFI	CATE O	F DEATH	REG. N	VO.					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
		Helen Walsh	ı	THOMPSON			MONTH 1 1	7 199°	AR 6.10 M				
,		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign				
		235-52-3274	1 M 2 V F	38 YRS.	MONTHS DAYS	HOURE MIN.	(Month, Day, Year))	Country)				
pino		9a. FACILITY NAME (If not institution, give str			Ab CITY TOWN	N OR LOCATION OF D	2-14-19		Rowlesburg				
8	Œ						EAIR	9c. COUNTY	OF DEATH				
2,	2	Garrett County Me	morel Hospit	al [0al	<u>kland</u>		Gar	rett				
es	E C	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOC	CATION			10d, INSIDE CITY				
Z.	DIRECTOR	WV Pres	ton		Rowles	sburg			LIMITS?				
je j		10e. STREET AND NUMBER				10f. ZIP CODE		100 CITIZEN	OF WHAT COUNTRY?				
physician. bunal-transit permit. Pages 1, 2, 3 should	FUNERAL	P.O. Box 133				26452			S.A.				
cian. Ftran	Ž	11. MARITAL STATUS	12. WAS DECEDENT EVER I	NIIS ARMED	12 WAS D	ECENDENT OF HISPA	NIC OBICING (BIII						
physician burial-trai		1 Never Married 2 Married	FORCES? 1 YES	2 VNO	If yes,	specify Cuban, Maxica	in, Puerto Ricen, etc.)	14.	RACE — American Indian, Black, White, atc.				
	B	3 Wildowed 4 Divorced	IP TES, GIVE WAR OR D	AIES	1 4	ES 2 X NO Specif	y:		Specify:				
ttend e as		15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S U	ISUAL OCCUPA	TION	16h KIND OF	BUSINESS/INDUST	White				
or a		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wo	ork done during retired.)	most of working	1,						
spital ed fe	7	201127	4	Nurse	2		Nun	rsing					
the hospital or att detached for use once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18 MOTHED'S NA	ME (First, Middle, Maid						
# 6 %	U U	John Edward	WAlsh			Cosie	That, Micole, Maic	- Surname)	Grimm				
ould be	0	19a. INFORMANT'S NAME (Type/Print)	MATON	105 MAIL INC.	Popped (or								
5 should notified	임	Cosa Ann Thompson				Rowlest			(in)				
		20a. METHOD OF DISPOSITION		_									
		1 Buriel 2 Cremation 3 Remo	oval from State Cen	netery, cremetory or oth Mt. Carme	F DISPOSITION (ecplece)	Neme of		LOCATION — City					
direc	- 1	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		Mt. Carme				Aurora,	WV				
death, Page 6 ma e funeral director, p J. examiner must	- 8	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22. NAME Ste	AND ADDRESS OF FA	eral Home						
deat e fun exa		Snadly A	Stevan					Dakland.	MD 21550				
d in by the or removal		23. PART i. Enter the diseases, or co	omplications that cause	d the death. Do no	ot enter the n	node of dving, suc	h as cerdisc or re-	eniratory arrest	21550 Approximate				
hours ed in b or rer		enock, or heart fallure. L	let only one ceuse on e	ech fine.				aprilately effect,	interval Between				
		IMMEDIATE CAUSE (Finsi disesse or condition	60.	NIDO	1-	5/ /			Onset and Death				
ompletely fille il, cremation, event, the		resulting in death)	DUE TO (OP 40.	Clogph	10 1	MOCIC							
completely rial, cremati			DOE TO (OH AS)	CONSEQUENCE (OF)	:	Shock	-/		116				
n certificate be executed within 2x1 indigning physician and completely file Hygiene prior to burlal, cremation, or other traumatic event, the	CERTIFICATION	Sequentielly list conditions,	TCU	CONSEQUENCE OF	10 cerse	1 /w	action		41100				
be cian ior to	F	cause. Enter UNDERLYING											
he death certificate be to the attending physician Mental Hygiene prior to njury, or other traun	유	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
h certificat anding phy Hygiene p Or other	Ē	resulting in death) LAST											
= 0 -	ij	d											
that the death certificate ed by the attending physic th and Mental Hygiene pri any Injury, or other th		PART II. Other significent conditions	contributing to death b	out not resulting in	the underly	ing ceuse given in		AN AUTOPSY	24b. WERE AUTOPSY FINDINGS				
that the	EDICAL	7-3						ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
es afte		A .					1 U YES	2 DXQ	OF DEATH?				
w requires been sign pt. of Heal 3 shows	Σ	DID TOBACCO USE CONTR	IDLITE TO CALLSE O	E DEATH VEC	Пио	LINICEDTAL			1 YES 2 NO				
2 8 8 C	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH			ч 🗆 📗						
SICIAN: The certificate h the State h th or Item	2	EXAMINER?	HOSPITAL:		OTHER:								
CLAN ertific the S	ΥS	1 YES 2 NO	1 Inpatient 2 ER/Outp			ome 5 🗆 Residence							
PHYS this c with rrked,	급	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	RY V	NJURY AT VORK?	28d. DEŞCRIBE HOY	W INJURY OCCUR	ED				
DING PHYS After this death with	B	2 Accident Investigation				YES 2 NO							
R: A er de	0	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	' — At home, farm, str	rest, lectory, of	fice	28f. LOCATION (Stree City or Town, Ste	et and Number or R	lural Route Number,				
L OR ATTENDING F DIRECTOR: After I hours after death item 28 is mar	ETE	4 Homicide determined											
DIRE hours	7	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	ledge, death occurred	at the lime, de	ite and place, and due	to the cause(a) and /	nenner as stated.					
HOSPITAL FUNERAL within 72 I	2								use(a) end manner as stated.				
THE HOSPI THE FUNEF filed within	8	296. SIGNATURE AND TITLE OF ESPITIFIER	111										
물 물 물	H		//	m		29c. LICENSE NU	MBER	29d. DATE SIG	NED (Month, Day, Year)				
263₹	2	30. NAME AND ADDRESS OF PERSON WHO	etwa ereactive or or	ATH (ITEM OT) (T)	D-/mel	D23979		1 11/	4/96 ·				
		_											
		Robert A. Goralsk 31. DATE FILED (Month, Day, Year)		V. Fourth	Street	t Oakland	MD 2155	0					
			32 REGISTRAR'S SIGN	P. O AD									
	6	NOV 0 9 1995	HALLY CORPORATION	Mardall									



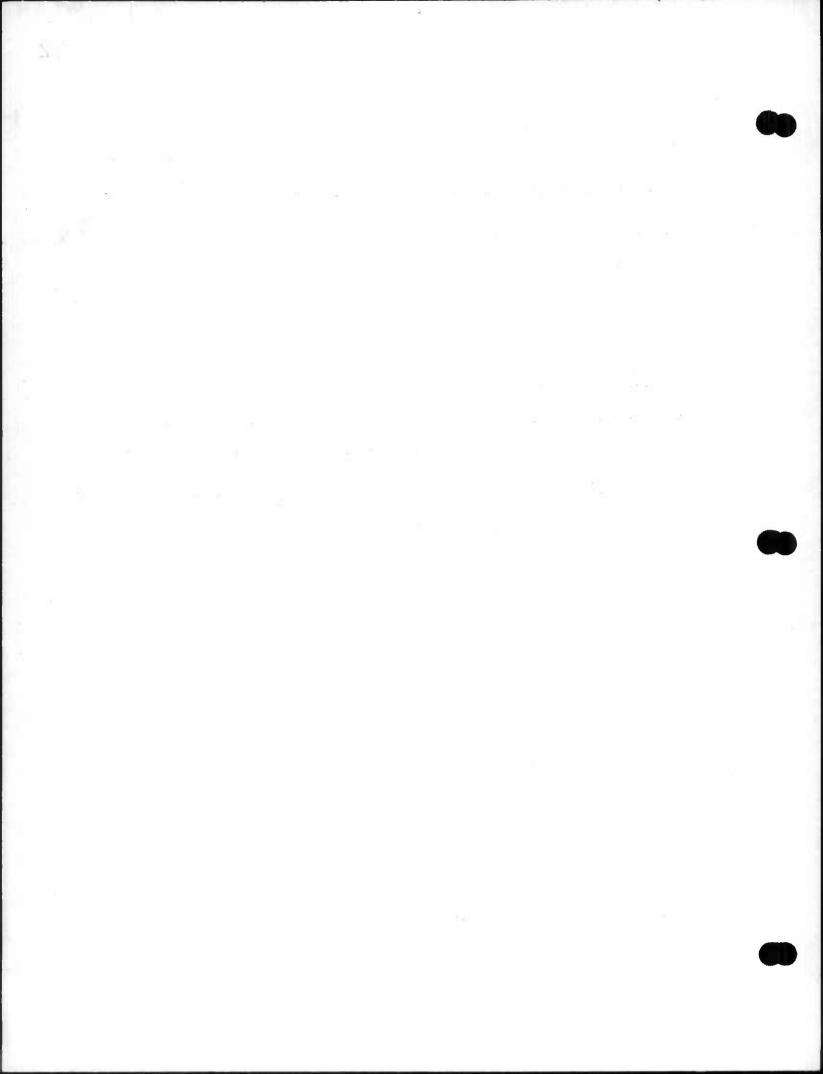
DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

	HEGISTHAN		- CE	ENTIF	CAIL	UF	DEAL	П	P	EG. NO.			
	1. DECEDENT'S HAME (First, Middle, Lest) WILLIAM JOHN	LIDDAN							2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	URBAN							NOVE		5,19		9:30 a M
		5. SEX	6. AGE (In yrs. las		IF UNDER 1	YEAR	IF UNDER	24 HRS. MIN,	7. DATE OF E	HRTH y, Ybac)	1000	8. BIRTH	SCONSIN
	387-01-5526		86	THS.						14,			
~	9a. FACILITY HAME (If not institution, give st			96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY									
DIRECTOR	THE JOHNS HOPKIN		BALT	CIMC	RE C	ITY			E	BALT	IMORE		
2	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY	,											
Œ					TOWN OR								10d. INSIDE CITY LIMITS?
	MARYLAND QUEE	CE	CENTREVILLE								1 TYES 2 HO		
₹	10e. STREET AND NUMBER			101	. ZIP CODE				10g. CITI		VHAT COUNTRY?		
FUNERAL	108 ASHLEY DRI	VE					21	617				USA	
ا ۾	11. MARITAL STATUS	12. WAS DECEOENT	EVER IH U.S. AR	MED	13. W	AS DEC	ENDENT OF	F HISPANI	C ORIGIN? (S	pecify Yea	or Ho-	14. RACE	E — American Indien, k, White, etc.
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	R OR DATES		1 [Yes, sp	2 X NO	Specify:	, Puerto Ricer	i, arc.)	- 1	Speci	
													WHITE
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		(Gi	CEDENT'S L	ork done du			a	16b, KIN	D OF BUS	HESS/IND	USTRY	
ا ۳	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT use									
₹	12	4	EN	GINE	ER				INI	UST	RIAI	MI	₹G.
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAM	IE (First, Middl	e, Maiden S	Surname)		
BE	JOHN J. URBAN						MAF	RY K	ATHE	RINE	Ver	HAL	EN
10	19a. IHFORMANT'S NAME (Type/Print)		19t	. MAILIHG	ADDRESS ((Street a	nd Number	or Rural Ad	oute Number, C	illy or Town	, State, Zip	Code)	
F	MARY HELEN FRI	EL	2	04 A	SHLI	EY	DRIV	Æ,	CENTI	EVI	LLE,	MD	21617
	20a, METHOD OF DISPOSITION		20b. PLACE A						OATE	20c. LOC	ATIOH —	City or To	wn, State
	4 Donation 5 Other (Specify)	Oval from Stata	ST. P	TETER	er place) CI	DIMID	TERY	1	1-9	OUE	ENST	OWN	, MD
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22 N/	AME AH	ID ADDRES	S OF EAC	HITV				•
	M. Er Nei		加个	(cf) N I	EWN	AM F	UNE	RAL I	IOME	, P.	Α.	
_	IV Nel	Mack		704	20	00	<u>s.</u> E	IARR	ISON	ST.	, E <i>P</i>	ASTC	N, MD
1	23. PART i. Enter the diseases, or of shock, or heart failure.	omplications that List only one caus	caused tha da	ath. Do no	ot anter ti	ha mo	da of dyir	ng, such	as cardiac	or respir	atory arre	ent,	Approximate interval Between
	IMMEDIATE CAUSE (Final												Onset and Death
H	disesse or condition resulting in death)	3 RM	DY APRY	THMO	A								4 Monumes
- 1		OUE TO (OR AS A COHSEC	UEHCE OF	:								7712100763
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CERTIFICATION	Sequantially list conditions, if sny, landing to immediate	DUE TO (OR AS A CONSEC	UENCE OF	:								1
<u>ই</u> ∥	CAUSE (Disease or injury	Desse	May Min	3	CA	aci	mon	A-					LYEMR
쁜	that initiated events	DUE TO (OR AS A CONSEC	UENCE OF	:								
H	resulting in desth) LAST	1											
	PART II. Other aignificant condition	a contributing to a	laath but not re	essiting in	the und	le elvino	Cauca d	iven in D	hart I have	. WAS AN	HITOBOY	1	
EDICAL										PERFORI		240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	PROSTATE CONCER	Tayre	100 GO 57	ALL.	my	(Le	UURZ	an.	10	YES 2	NO.		OF DEATH?
Σ	Corpunty ALT								_ ,				1 - YES 2 -40
ž	DID TOBACCO USE CONTR	RIBUTE TO CAL					UNC	ERTAIN	K				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	E OF OEAT									
Š	1 - YES 2 - 410	10 Inpatient 2	ER/Outpatient 3		OTHER:		5 Res	idence 6	Other (Sp	ecify)			
3	27. MAHHER OF DEATH	28e. OATE OF II (Month, Day	HJURY (Year)	28b. TIME IHJU		8c. IHJU	JRY AT		28d. OESCRIE	E HOW IN	JURY OCC	UREO	
B	Natural 5 Pending 2 Accident Investigation		,,		М	1 🗌 Y		KNO					
		28a. PLACE OF	IHJURY — At hor	na, farm, at	rest, fector	y, office	,		281. LOCATIO	H (Street ar	nd Number	or Rural R	loute Number,
	3 Suicide 8 Could not be		te. (opoony)						Uny or 10	wn, State)			
2 1	4 Homicide 8 Could not be												
LETE	4 Homicide determined	CIAH: To the heat of m	w knowledge de-	th occur-	at the st-	an alman	and aless	mand of the co	the entire			41	
MPLETE	4 Homicide determined 29e. CERTIFIER (Check only) 1 CERTIFYIHG PHYSIC												
COMPLETED	29e. CERTIFIER (Check only one) 29 MEDICAL EXAMINE	R: On the beels of exa					eath occure	d at the ti	lme, data and) and manner as stated.
	4 Homicide determined 29e. CERTIFIER (Check only) 1 CERTIFYIHG PHYSIC	R: On the beels of exa						d at the ti	lme, data and		I due to the	cavee(s) and manner as stated. (Month, Day, Year)
띪	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINED 29b. SIGNATURE AND TITLE OF CERTIFIER	R: On the beals of exa	minstion and/or le	nveatigation	, in my opi		29c, LICE	d at the ti	ime, data and		29d. DATE	SIGNED	
	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	On the beals of exa	E OF DEATH (ITEM	1 27) (Type, i	, in my opi		29c, LICE	d at the ti	ime, data and		29d. DATE	SIGNED	(Month, Day, Year)
띪	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WAS 20th O STRCZ January	COMPLETED CAUSE	E OF DEATH (ITEM	1 27) (Type, i	, in my opi	Inlen, de	29c, LICER	HSE HUME	BER	place, and	29d. DATE	SIGNED	(Month, Day, Year) EN. S, 1975
띪	4 Homicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	On the beals of exa	E OF DEATH (ITEM	1 27) (Type, i	, in my opi	Inlen, de	29c, LICER	HSE HUME	BER	place, and	29d. DATE	SIGNED	(Month, Day, Year)

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death criticate be executed withmen hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNESTOR that this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARY	LAND / DEPARTME CERTIFICA	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH							
	Virginia Ellen Veasey			November 2 1	1995 7:50 pM							
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AG		DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign							
	219 - 34 - 0222 ¹□м²⊠ғ	79 YRS. MONTH		ebruary 22 19	Old New York							
_	9a. FACILITY NAME (If not institution, give street and number)	9b. C	TTY, TOWN OR LOCATION OF		COUNTY OF DEATH							
E	Medpointe Continuing Care Fa	cility	E1kton		Cecil							
EC	10a. STATE 10b. COUNTY		N OR LOCATION		10d. INSIDE CITY							
DIRECTOR	Maryland Cecil	No	th East		LIMITS?							
	10e. STREET AND NUMBER	1	101. ZIP CODE	109	g. CITIZEN OF WHAT COUNTRY?							
BY FUNERAL	56 Old Log Cabin Road 21901 United S											
5	11. MARITAL STATUS 12. WAS DECEDENT EVER		13. WAS DECENDENT OF HISP	ANIC ORIGIN? (Specify Yea or N								
<u>×</u>	1 Never Married 2 Married IF YES, GIVE WAR OR		If yes, specify Cuban, Mexi		Specify: White							
	15. DECEDENT'S EDUCATION	Tes December 10 1011										
COMPLETED	(Specify only highest grade completed)	(Give kind of work do life. Do NOT use retire	ne during most of working d.)	16b. KIND OF BUSINES	is/industry							
PL	Elementary/Secondary (0-12) College (1-4 or 5+)	Homemaker		Her Own	Home							
O	17. FATHER'S NAME (First, Middle, Last)	110111011101	16. MOTHER'S N	IAME (First, Middle, Melden Surns								
BE C	Martin Luther Morris		Eli	zabeth Kelly								
TO B	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDR		I Route Number, City or Town, Sta	ite, Zip Code)							
F	Ralph T. Veasey, Jr.	64 Old I	og Cabin Roa	d, North East	:, MD 21901							
	20a. METHOD OF DISPOSITION 1 🔀 Burlel 2 🗆 Cremation 3 🗀 Ramoval Irom State	b. PLACE AND DATE OF DISE	OSITION (Name of	DATE 20c. LOCATIO	DN — City or Town, Stata							
	4 Donation 6 Other (Specify) N	orth East Me	thodist Cem.	11/7 North	East, Maryland							
	1/1/19/1/		Crouch Funera									
	With City				th East, MD 21901							
	23. PART I. Enter the diseases, or complications that caus shock, or heart feilure. Liet only one cause on	ed the deeth. Do not en	ter the mode of dying, su	ch es cerdiec or reepirator	ry srrest, Approximate Interval Between							
	iMMEDIATE CAUSE (Fine) disease or condition	D			Onset and Death							
	resulting in death) a.											
_	OF TO (On as a Consequence OF):											
<u>o</u>	Sequentisity list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
S	cause. Enter UNDERLYING CAUSE (Disease or Injury											
E	that initiated events DUE TO (OR AS	A CONSEQUENCE DF):										
CERTIFICATION	resulting in desth) LAST											
AL C	PART II. Other significent conditions contributing to deeth	but not resulting in the	underlying cause given i	Part I. 24s. WAS AN AUTO								
SC				PERFORMED	COMPLETION OF CAUSE							
MEDIC					OF DEATH? 1 □ YES 2 ☑ NO							
	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	NO UNCERTA	IN 🗆								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	28. PLACE OF DEATH (Che										
, Si	1 YES 2 NO 1 Inpatient 2 ER/Ou	ipetiant 3 DOA 4 D	JER: Nursing Home 5 ☐ Residence	6 Other (Specify)								
H	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 1 Natural 5 Pending	WILLIAM	28c. INJURY AT WORK?	26d. DESCRIBE HOW INJUR	Y OCCURED							
BY	2 Accident Investigation		1 YES 2 NO									
	3 Suicide 6 Could not be 4 Homicide determined	IY — At home, farm, street, ecity)	actory, offica	281. LOCATION (Street and No City or Town, State)	umber or Rural Route Number,							
COMPLETED	An opposition											
MP.	(Check only 1 CEHTIFYING PHYSICIAN: To the beat of my kno											
00	One) 2 MEDICAL EXAMINER: On the basis of examination	on end/or investigation, in m	y opinion, death occured at th	e lime, date and placa, and due	to the cause(a) and manner as stated.							
BE	296. SIGNATURE AND TITLE OF CERTIFIER Sullevillar S Sache		29c. LICENSE NO	- 116.5	I. DATE SIGNED (Month, Day, Year)							
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D	-	カマ	3322 >	11/3/40							
}			MD 01001									
	Dr. S. Sachdev, 118 North St. 31. DATE FILED (MOOTH, PRI JOSE) 32, REGISTRAR'S GIG	NATURE	MD 21921									
	NOV 06, 1995 Julia a Registranis 310	tall										



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

ROBERTO

4. SOCIAL SECURITY NUMBER

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1XXM 2 □ F 143-64-3721 25 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Saint Joseph Medical Center Towson, Maryland RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 18b. COUNTY Maryland Baltimore County White Marsh permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 5 Belridge Road 21237 the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, stc.)

XIX YES 2 NO Specify: XX Never Married 2 Married В 3 Widowed 4 Divorced use as ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade comp ng most of working ğ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Computer Analyst should be detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roberto A. Vega notified at Rosita A. Aranda 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberto A. Vega 26 Brumback Avenue, Luray, VA page pe 20s METHOD OF DISPOSITION
1 M Burlal 2 Cremation 3 Ramoval from State
4 Donalion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION /Name of must funeral director, Beahm's Chape<u>1 Cemetery</u> 1995 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner #M00690 22. NAME AND ADDRESS OF FACILITY The Bradley Funeral Home loward K ausen 187 East Main Street, Luray, VA n by the 1 removal. medicai 23. PART i. Enter the disesses, or complications that caused the desih. Do not enter the mode of dying, such as cardiac or raspiratory arrest, filled in by shock, or heert feilure. Liet only one ceuee on eech line. 0 IMMEDIATE CAUSE (Fine) cremation, the disease or condition CARDIAC ARREST completely recuiting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) burial, MULTISYSTEM ORGAN FAILURE CERTIFICATION and Sequentielly liet conditione, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate prior to physician ADULT RESPIRATORY DISTRESS SYNDROME cause. Enter UNDERLYING other CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) Hygiene thet initieted events resulting in deeth) LAST 0 Mental Injury, the PART ii. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Pert i. MEDICAL and and shows any Signed 1 STATUS POST AORTIC VALVE REPLACEMENT been 1. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN PHYSICIAN: has be Dept. WE 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL The Hem certificate ? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Realdence 8 □ Other (Specify) 1 - YES 2 ->6 etlent 2 - ER/Outpatient 3 - DOA PHYSICIAN: this certification with the 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 1 Netural
2 Accident 5 Pending Investigation 1 YES 2 NO BY death After OR ATTENDING 28a. PLACE OF INJURY — Al home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28 Is 8 Could not be COMPLETED DIRECTOR: after POULS Hem 29a. CERTIFIER

//Check only

1 DEFITIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL F within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER RC Steward -D38655 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. STEWART FINNEY,M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204 31. DATE FILED (Month, Day, Year) 32 REGISTIAR'S SIGNATUR OCT 31 1995

Antonio

5. SEX

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS

MIN.

HOURS

VEGA

8. AGE (In yrs. last birthday)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. OATE OF DEATH DAY 3. TIME OF DEATH YEAR Oct 23 1995 7:46 am w 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign January 12,1970 New Jersey 9c. COUNTY OF DEATH Baltimore 10d. INSIDE CITY 1 YES 2 NO United States of America 14. RACE — American Indian, Black, White, atc. White 16b. KIND OF BUSINESS/INDUSTRY United States Department of Agriculture 22835 16726 20c, LOCATION — City or Town, Siste Luray, Virginia Approximate interval Batween **Onset and Death** Minuter 12 Hours 4 Days 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | 10 OF DEATH? 1 TES 2 0 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Mgnth, Day, Your)

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TO THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAD STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAH		C	Eniir	ICALE	· UF	DEATH		REG. NO.			
,	1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA	RUTH		VAL	ENT	INE		2. DATE OF MONTH	DEATH DA	19	gyear g	3. TIME OF OEATH 9:33 P M
	4. SOCIAL SECURITY NUMBER 220-78-0823	5. SEX 1 M 2 F	6. AGE (In yrs. las	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF OCT 1	виятн Т., 19	16	8. BIRTHP Country,	LACE (State or Foreign
OR	98. FACILITY NAME (If not institution, give si MEMORIAL HOSPITA)		***				RLAND	ATH			NTY OF DE	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY											
FUNERAL DIRECTOR	MD Alle			y, town o lberl	and					- 1	10d. INSIDE CITY LIMITS? 14 YES 2 NO	
IERAI	428 Arch Street		101. ZIP CODE 21502				10g. CITIZEN OF WI USA				fat country?	
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Olvorced	EVER IN U.S. AR YES 2 N IR OR DATES	245 NO If ye			ENDENT OF HISPAN ecific Cuban, Mexica 2 NO Specifi	n, Puarto Rici	Rican, atc.) Black,			– American Indian, White, atc. hite	
	15. OECEOENT'S EDUC		18a. DE	CEOENT'S	USUAL OC	CUPATIO	ON .	16b. KI	ND OF BUS	INESS/IND		
COMPLETED	(Specify only highest grade	College (1-4 or 5+)		(Give kind of work done during most of working life. Do NOT use retired.) Hamemaker					wn Ho	me		
S I	17. FATHER'S NAME (First, Middle, Last)				-		18. MOTHER'S NA	ME (First, Mide	dle, Maiden	Sumame)		
BEC	Andrew Jack Ga	noe						Pearl				_
5	19a. INFORMANT'S NAME (Type/Print) Thomas Valentine		12	3 EL	eano	(Street a	nd Number or Aural I treet; C	Poute Number, umber	City or Town	MD	2150)2
	7 METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremetion 3 □ Remote 4 □ Donation 5 □ Other (Specify)	oval from State		EAND DATE 20c. LOCATION — COMMISSION — COM							and,	n, Stata MD
	21. SEGNATURE OF FUNERAL SERVICE LIC	ENSEE \	0-	Sc	TIMBO	elli Fun rland, M	eral I	Home				
\dashv	23 DAUT I Enter the diseases or	7-200	er pass	X.(•					
	23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Fine)	List only one caus	e on each line	on, Dor	lot enter	the mo	de of dying, suc	h as cardia	c or respir	ratory en	rest,	Approximete interval Between Onset and Death
	disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of):										24 Hours	
NO	Sequentially list conditions, if any, leading to immediate Due To (or As A consequence of):											5 Years
FICAT	cause. Enter UNDERLYING CAUSE (Disease or injury											
CERTIFICATION	that initieted evente resulting in death) LAST											
EDICAL	Chronic Obstruct	contributing to dive Pulm	onary D	ot resulting in the underlying ceuse given in Pa Disease				Part i. 24a. WAS AN AUTOPSY PERFORMED?				WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
MED I	Cerebrovascular	Accident						_ '	☐ 1E3 2·	€ NO		OF DEATH?
	DID TOBACCO USE CONTR	RIBUTE TO CAL	JSE OF DEA	TH YE	S 🗆 N	10 🔀	UNCERTAIL	4 D				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: ,,		E OF DEAT								
YSI	1 TYES 2 NO	1 Inpetient 2	ER/Outpatiant 3	□ DOA	OTHER		5 🗆 Residence	8 Other (S	(pecify)			
BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF I (Month, Da		28b. TIMI INJ	E OF URY M		URY AT RK? 'ES 2 NO	28d. DESCR	IBE HOW IN	JURY OC	CURED	
	3 Suicide 8 Could not be determined	28a. PLACE OF building, a	INJURY — At hortc. (Specify)	me, larm, s	ntreel, facto	ory, office		281. LOCATION OF T	ON (Street a fown, State)	nd Number	or Rural Ro	ute Number,
COMPLETED	29a. CERTIFIER (Check only one) 29a. The beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
TO BE	V.A. Kenyth	OL M COMPLETED CAUSE	OF DEATH ATER	4 27) /hea	Print)		D197	250		▶ A	/ DV .	6th 95
	DR RANJITHA		,			CUM	BERLAND	O MD	2150	2		
	31. DATE FILED (Month, Day, War) NOV 0.7 1995	32. REGISTRAF	'S SIGNATURE									
		U .										

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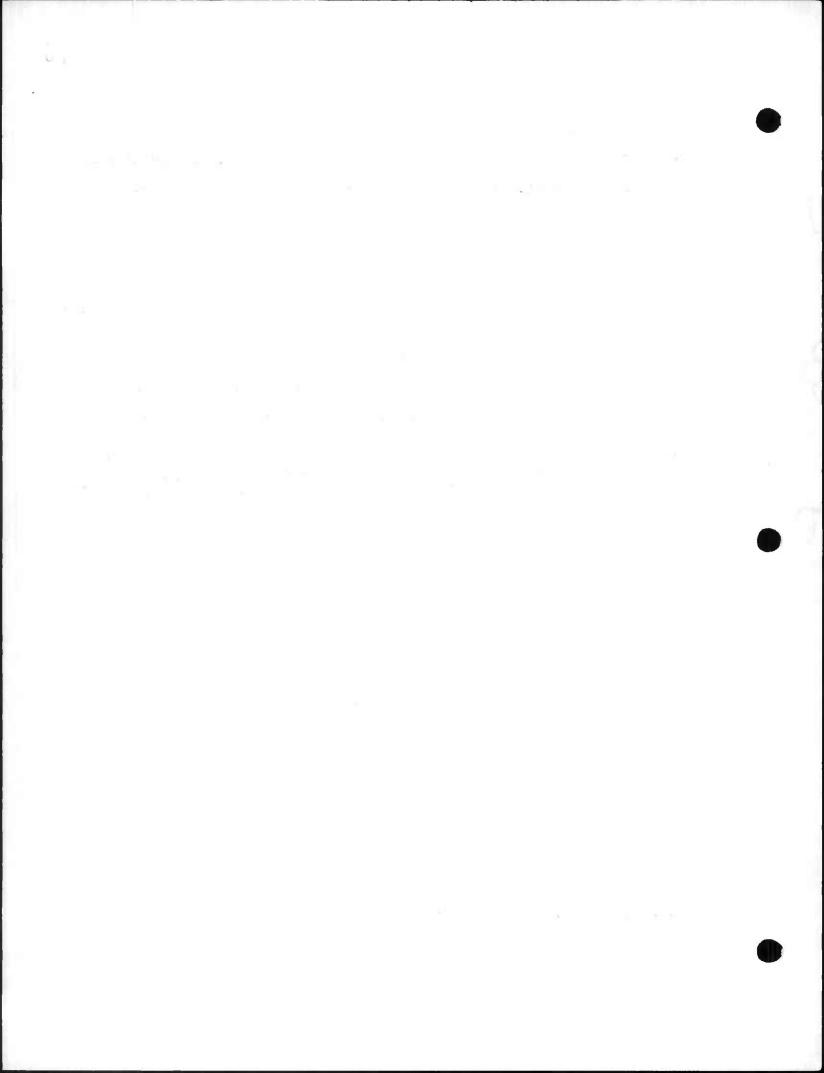
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permit. burial-transit Page 6 may be retained by the hospital or attending physician. use as the page 5 should be detached for once. notified at pe must n and completely filled in by the funeral director, to bunal, cremation, or removal. medical examiner hours after death. the executed within traumatic event, attending physician 8 prior other ö signed by the atter Health and Mental L. of H Dept. 23 has Hem certificate h 0 this c marked, After 1 .09 DIRECTOR after 28 hours item TO THE HOSPITAL (
TO THE FUNERAL C
Be filed within 72 h
IMPORTANT: It is

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Nov Alma 120 allee PH -Imata 1995 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign Country) 1 M 2 X F 214-05-6881 AUG. MARYLAND 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ALLEGANY FROSTBURG FROSTBURG VILLAGE NURSING HOME RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND LA VALE t TYES 2 NO ALLEGANY 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? **ROUTE 5 WINCHESTER ROAD** 21502 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced WHITE ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 9 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) GEORGE RAYMOND DUCKWORTH MARGARET ELIZABETH O'DAY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 RT 1 BOX 192 B, RIDGELEY, WV 26753 ANTHONY MC KENZIE 20a. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Nov 7.95 20c. LOCATION - City or Town, State Donation 5 C Other (Specify) MICHAEL'S CATHOLIC CEMETERY FROSTBURG, MD MATURE OF FUNIFIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
HAFER CHAPEL OF THE HILLS MORTUARY See 1302 NATIONAL HWY, LA VALE, MD 21502 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List Dniy ona causa on each line. intarvai Between IMMEDIATE CAUSE (Final Onset and Daath disease or condition P839 Myocarbal acute reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Coronory
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): 20 Jeans cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Promie PERFORMED? aspiralin Spring 1 TYES 2 TO NO mre di Enl Except. 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES M NO PHYSICIAN: UNCERTAIN [25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one, OTHER:
4 Mursing Homa 5 - Residence 6 - Other (Specify) HOSPITAL 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 28b. TIME OF INJURY 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending м 1 YES 2 NO ВҰ Investigation 2 Accident 28a. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 6 Could not be 4 Homicide determined COMPLET 29a. CERTIFIER 1 TCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner ea stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) WOLL 6 -ow 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

S.L. SANDHIR MD, 48 TARN TERRACE, FROSTBURG, MD 21532 32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year) NOV 07 1995



FOR STATE REGISTRAR

1 -

DIVISION OF VITAL RECORDS, P.O. BOX 13146, Secured within A note after death. Page 6 may be retained by the hospital or attending physician.

		1. DECEDENT'S NAME (First, Middle, Last) Blanck G. Wilt					bank.				2. DATE OF DEATH DAY 3			TIME OF DEATH
		4. SOCIAL SECURITY NUMB 221-32-0537	EA	5. SEX	6. AGE (In y	rs. last birthday	MONTHS	1 YEAR	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Yea April 23	1007	Country)	ACE (State or Foreign
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3 should	R	Medpointe of Elkton					96. CITY, TOWN OR LOCATION OF DEATH Elkton					Cecil		
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Pages	DIRECTOR	Maryland	10b. COUNT				TY, TOWN		ATION					LIMITS?
armit.		10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WH/												
nsit p	ER/	#1 Price Drive 21921 USA												
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must		1 ☑ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		noval from State	_ Grac	e lawn	Memo	ria	1 Par	k				elaware
e funeral dir I. examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSES. 22. NAME AND ADDRESS OF FACILITY Spicer-Mullikin Funeral Homes, Inc. 1000 N. DuPont Pkwy, New Castle, DE 19720												
signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Health and Mental Hygiene prior to burial, cremation, or removal. was any injury, or other traumatic event, the medical examiner must be notified at once.	CERTIFICATION	23. PART I. Enter the diseasea, pr complicatione that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory erreet, ehock, or heart fellure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in desth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST Approximate mode of dying, such as cardiec or reepiratory erreet, ehock, or heart fellure. List only one ceuse on each line. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
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After this ce leath with the marked,	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME F 28c. INJURY AT WORK? 1 YES 2 NO 28d. DESCRIBE NOW INJURY OCCURED												
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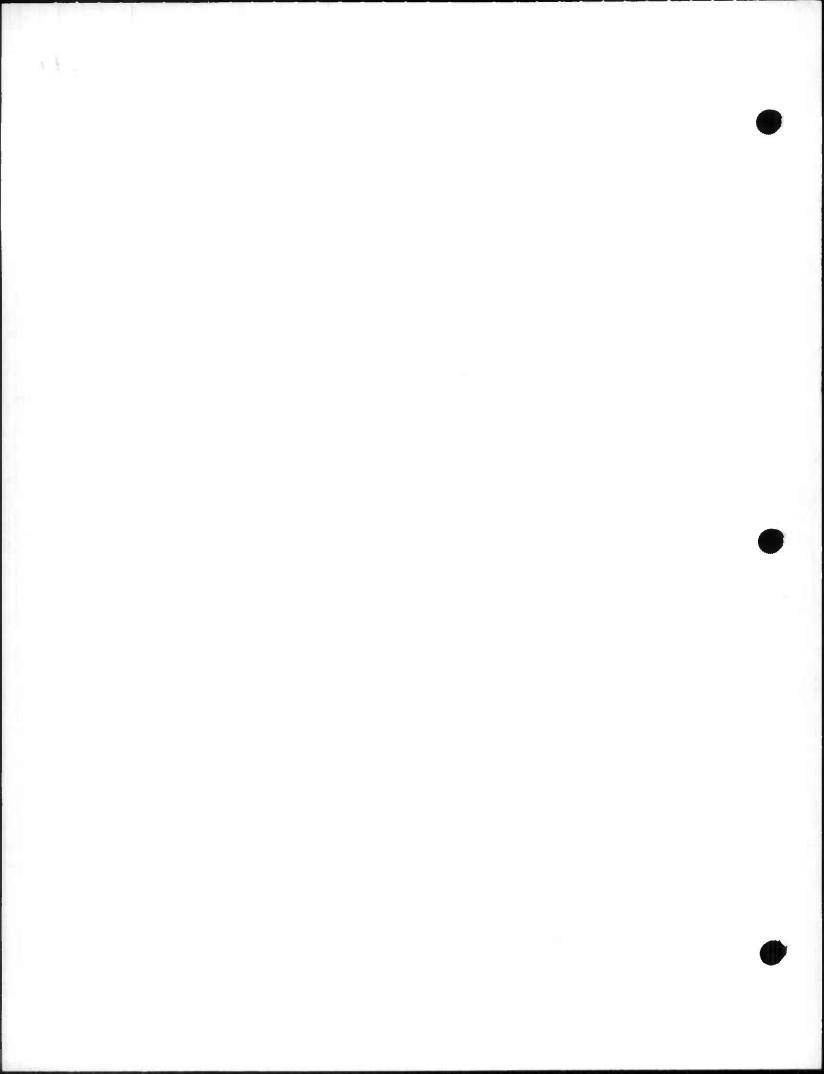
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)						ATE OF DEATH		3. TIME OF DEATH		
	Mabel Ward Wil		No	1100 A M							
			E (In yrs. last birtnday)	IF UNDER 1 YEAR		7. DA	OVEMBEI	8	BIRTHPLACE (State or Foreign		
	213 50 6052 1 9a. FACILITY NAME (If not institution, give stree		3 YRS.	MONTHS DAYS			irch 21		Maryland		
Œ	Prince Frederick House Nursing Home 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince Frederick Calvert										
5	RESIDENCE OF DECEDENT		-5 -10-110	1111100				Culve			
DIRECTOR	Maryland Calvert Prince Freder:						100.				
FUNERAL	104 STREET AND NUMBER 215 Main Street		101. ZIP CODE 10g. CITIZEN OF WHAT COUNTY 20678 UNited State								
N	11. MARITAL STATUS 1:	13. WAS D	ECENDENT OF HISPA	NIC OBI	GIN? (Specify Vec						
	1 Never Married 2 Married	FORCES? 1 YE	8 2 NO	If yea,	specify Cuban, Mexic	en, Puer		GI NO-	Black, White, etc., Specify: White		
m v2 moves + brokes								Specify: 11111 CC			
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₹	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NOUSEWIFE 18. MOTHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										
8											
william Spickhall ward Grace Louise Sunderland											
2	Jane W. Leitch 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 910 Huntingtown, Maryland 20639										
	1 N Buriel 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	I from State	ob. PLACE AND DATE (Ametery, cremetory or o ENLIAL C	ther place)	Neme of Q 1	905	ATE 20c. LO		y or Town, State Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICEN		entrar C		AND ADDRESS OF F		Dal	SLOW I	arytanu		
	· 690	1000/	1						eral Home		
\dashv	23 PART I Enter the diseases or con	aplications that save	ad the death. De-						public MD 20676		
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	iMMEDIATE CAUSE (Final disease or condition		1 -	He	1 61		0		Onset and Death		
	resulting in death)	DIE TO (DR AS	A CONSEQUENCE OF	1100	1 Tail	w					
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ō	Sequentially list conditions, if any, leading to immediate	DUE TO (DR AS A CONSEQUENCE OF): Attuscilente Cadovascul d'scal DUE TO (OR AS A CONSEQUENCE OF):							14479		
CAT	cause. Enter UNDERLYING								19 cas		
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):							
CERTIFICATION	reaulting in death) LAST										
	PART II. Other significent conditions of	ontributing to death	but not resulting i	in the underly	na cause abon in	Dort I	24a, WAS AN	AAPPO DOW			
SAL		and the description	Dut not resulting t	in the directly	ing cause given in	Part I.	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
<u> </u>							1 YES 2	No	COMPLETION OF CAUSE OF DEATH?		
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
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<u>></u> ∥	27. MANNER OF DEATH	28a. DATE OF INJURY			me 5 Residence		ther (Specify) DESCRIBE HOW IN	LIURY OCCUR)FD		
I I	Netural 5 Pending	(Month, Day, Year)		URY	ORK?	100.	DESCRIBE NOW II	WONT OCCOR	ieu		
Y PHYSICIAN: MEDIC	2 Accident Investigation 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or							Rural Boute Number			
B√	3 D Suidelde	28a. PLACE OF INJUR	Y — At home, ferm, s	treet, factory, off	Ica	281. L	OCATION (Street a	nd Number or	Rural Route Number		
B√		28a. PLACE OF INJUR building, atc. (Sp	iY — At home, farm, secify)	street, factory, off	Ica	281. L	OCATION (Street a lity or Town, State)	nd Number or	Rural Route Number,		
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Pages 1, 2, 3 should use as the burial-transit permit. beath. Page 6 may be retained by the hospital or attending physician, funeral director, page 5 should be detached for use as the burial-tran BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be n by the f in by filled and completely fa

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DIRECTOR: A hours after de item 28 is .00

TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: It item 2

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HOSPITAL

68760 executed BOX requires that the death certificate be DIVISION OF VITAL RECORDS, P.O. OR ATTENDING PHYSICIAN: The law

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 2,1995 NOVEMBER 3:45 WILLS SR. PM LEROY CHARLES 7. DATE OF BIRTH (Month, Day, Year)
Jan. 17, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 🕅 M 2 🗌 F 220-28-5286 63 1932 Maryland 9s. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH Benedict DIRECTOR MILL CREEK CHARLES COUNTY RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Calvert Prince Frederick 1 YES ZX NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 783 Mason Road 20678 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, Whits, etc. If yes, specify Cuben, Maxicen, Puerto Rican, etc.)

1 YES 2XXNO Specify: FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 XXMarried Specify Black ΒY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade comp ve kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 11 Laborer Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Haro1d Wills Mary BE 19s, INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Yvonne Wills P.O. Box 783 Prince Frederick, MD 20678 METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Nama of OATE Burist 2 Cremation 3 Removal from Stats

Donation 5 Other (Specify) Brown's Cemetery 11/7/95 | Port Republic, MD 22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 1451 Dares Beach Rd. Prince Frederick, MD pencer 23. PART I. enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert feilure. List only one cause on each line interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition DROWNING resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in death) LAST PART if. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF OEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 | Nursing Home | 5 | Residence | 6 X Other (Specify) | CREEK HOSPITAL 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 X YES 2 NO 28a. OATE OF INJURY (Month Day, Year) 27. MANNER OF DEATH 28d. OEŞCRIBE HOW INJURY OCCUREO 28b. TIME OF INJURY 28c. INJURY AT WORK? 11 2 95 NAURY — At home, farm, street, factory, office building, etc. (Specify) 1 Natural 5 Pending 1 YES 2 NO DROWNED BY Investigation 2 Accident 261. LOCATION (Street and Number of Bural Route Number, City or Town, State) 3 Suicide a Could not he daterminad COMPLETED 4 Homicide CHEEK HEAD OF MILL CREEK

O.C.M.E. NOVEMBER 3,1995 30. NAME AND ADDRESS OF WHO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Penn)

OLUTAL MW 111 Penn Street, Baltimore, Maryland 21201 GOLLE

29s. CERTIFIER

(Check note of the control of the c

XXMEDICAL EXAMINER: On the ossis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29s. LICENSE NUMBER

31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Talin Davidson Randoll NOV 1995

(Check only one)

OHMH-16 Rev 1/89

29st. DATE SIGNED (More), Day, West)

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nay be retained by the hospital or attending physician. TIMORE, MARYLAND 21215-0020

page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

once.

must be notified at

DOV COTE (٥ DECODE DIVISION OF VITAL

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 m	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deat

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	1 - STATE REGISTRAR	STATE OF N	MARYLAND C	DEPAR	ICATI	OF H	DEAT	AND I	MENT	AL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last							2. DA	TE OF DEATH	DAY	YEAR	3. TIME OF DEAT	ГН	
	C1eme		W	hite						ember	3, 1	995	5:00	рм
	4. SOCIAL SECURITY NUMBER 218-38-9008	5. SEX					MOI DAVE HOUSE AND (MOI			TE OF BIRTH onth, Day, Year)	nth, Day, Year) Coun		IPLACE (State or Fo	oreign
	9a. FACILITY NAME (If not institution, give	1 X M 2 □ F	5.	55 YRS.			May 21,			21, 1			aryland	
œ	1875 Adelina Ro			9b. CITY, TOWN OR LOCATION OF D						1	JNTY OF D			
FUNERAL DIRECTOR	18/5 Adelina Road Prince Frederick Calver								rt					
H H							10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY	,
□	Maryland Ca			Prin		rede						1 YES 2	NO	
AAL	10e. STREET AND NUMBER				101	ZIP COD	7			10g. CIT	IZEN OF V	VHAT COUNTRY?		
E	1525 Adelina Ro					206					US.			
	1 Never Married 2 Married	T EVER IN U.S. A	RMED NO		If yes, sp	ecify Cuba	in, Mexica	n, Puerl	GIN? (Specify) to Ricen, etc.)	es or No—		— American India c, White, etc.	en,	
Ä	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			1 TYES	2X ND	Specify	y:			Speci	"Black	
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	18a. D	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cement Finisher			1	6b. KIND OF B	USINESS/IN	DUSTRY					
	Elementary/Secondary (0-12)	-)												
M	17. FATHER'S NAME (First, Middle, Last)		Cer	nent .	Fini	sher	_				struc	tion		
8	Oliver	White	2				.1117.7	her's na 1m <i>a</i>	ME (Firs	t, Middle, Maide		T.Th d + .		
BE	19a. INFORMANT'S NAME (Type/Print)	***************************************		19b. MAILING ADDRESS (Street and Number or Rural Route I				Route No	umber City or T		White	3		
2	Mary White			1525 Adelina Road Prince Frederick, MD 20678										
	20a, METHOD OF DISPOSITION 1 A Buriel 2 Cremetion 3 Rec 4 Donation 6 Other (Specify)		20b. PLACE cometery, or Carro	20b. PLACE AND DATE of DISPOSITION (Name of Cametery, Creerappy of other place) Carroll Western Cemetery 11/8/95 Prince Frederick, M							MD			
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE			22.	NAME AF	D ADDRE	SS OF FA	CILITY	Sewell	Fune	ral I	lome	
	Spencer	E. S.	ewel	Q	145	51 D	ares	Bea	ch I	Rd. Pr	ince 1	Frede	erick, M	D
	23. PART i. Enter the diseases, or shock, or heart feilure	complications that List only one cau	t ceused the d	eath. Do r	not enter	the mo	de of dy	ing, suc	h as c	erdisc or res	piratory ar	rest,	Approxima	
	IMMEDIATE CAUSE (Final disease or condition	<i>c</i> , .			0 0	~	-				1		Onset and	
	resulting in death)	o. 5 qua OUE TO ES	MORAS A CONSE	DIJENCE DI			مم	LL	. 70		8		5 m	ones
7		Es	oph	-ou	.									
5	Sequentially list conditions, if any, leading to immediate	O	(DR AS A CONSE	7									-	
2	cause. Enter UNDERLYING CAUSE (Disesse or injury	с												
H	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	DUENCE OF	F):									
CERTIFICATION		d												
MEDICAL	PART II. Other significant condition	ons contributing to	death but not		in the un	derlying	ceuse g	given in	Part i.	PERF	N AUTOPSY	24b.	WERE AUTOPSY FIT AVAILABLE PRIOR COMPLETION OF C	TO
MED	Carebro Vascula Disame 1 yes 2 No OF DEATH?								27.25					

reprovascue usama DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

28. PLACE DF DEATH (Check only one) HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nesidence 8 - Other (Specify)

28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY

26c. INJURY AT WORK?

28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

9a. CERTIFIER		
(Check only	CENTIFYING PHYSICIAN: To the best of my knowledge	, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
one)		

one) 2 MEDICAL EXAMINER: On the basis of a	samination and/or investigation, in my opin	nion, death occured at the time, date and p	lace, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	Allender	29c. LICENSE NUMBER	29d, DATE SIGNED (Month, Day, Year)

29b. SIGNATURE AND TITLE OF CERTIFIER	m)	Allendy Physi-	29c. LICENSE NUMBER	27	29d. DATE SIGN	(Month, Day, Year)
Sul 30 3 10	HOS P	DF DEATH (ITEM 27) (Topo, Print)	FredelC	m)	20	678

31. DATE FILED (Month, Day, Year) NOV -7 1995

5 Pending Investigation

6 Could not be

32 REGISTRAR'S SIGNATURE Fulia Davidalle

5

COMPLETED BY PHYSICIAN:

BE

2

27. MANNER OF DEATH

1 Natural

2 Accident

3 Sulcide

4 Homicide

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1 1	REGISTRAR 1. DECEOENT'S NAME (First,	Middle, Last)			LEHI	TITICA	TE O	F DEAT		REG. NO.		3.	TIME OF DEATH
	ALYCE MA			V	VIG	14	7/	AN	•	Oct 31	1995	YEAR 1	0:45 a
	4. SOCIAL SECURITY NUMBER 236–16–9226		SEX	8. AGE (In yr.		MONT	NDER 1 YEAR		24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Sept 5, 1	220	Country)	ce (State or Foreign ylvania
	99. FACILITY NAME (If not ins			/ 5	,	-	CITY, TOW	N OR LOCATI				TY OF DEAT	
S S	Manor Care 1		R	uxto	n			Balt:	imore				
DIRECTOR	RESIDENCE OF DEC	19b. COUNTY			10c.	10c. CITY, TOWN OR LOCATION 10d, INSIDE C						I, INSIDE CITY	
la l	MD		Calve	rt		Prin	.ce	Freder	rick			LIMITS?	
3AL	10e. STREET AND NUMBER		1 7 1			101. ZIP CODE 10g. CITIZEN						COUNTRY?	
FUNERAL	470 West Dai		WAS DECEDENT	EVER IN II	RAPMEO	20678 USA LARMEO 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE						American Indian	
B	1 Never Merried 2 3 Wildowed 4 Divor	Merried	FORCES? 1 TYES 2 NO				If yee, specify Cuban, Mexicen, Puarto Ricen, etc.) 1 ☐ YES 2 ☑ NO Specify:			e or No- 14. RACE — American Indian, Black, White, etc. Specify: White			
TED	(Specify only	EDENT'S EDUCATION IN THE PROPERTY HIGHEST GRADE COM	pleted)		DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								
IPLE	Elementary/Secondary (0-	-12) C	ollege (1-4 or 5+		propr	ieto	r of	busir	ness	retail womens clothes		thes	
E COMPLET		17. FATHER'S NAME (First, Middle, Lust) Joseph L. Wisener					18. MOTHER'S NAME (First, Middle, Malden Surname) Charlotte Schmid					idt	
TO BE	196. INFORMANT'S NAME (TyperPrint) Mrs. Sue Smith 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Pimlico Way, Mt. Laurel, NJ 08054												
aust be	20e. METHOD OF OISPOSITION 1 17 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE DISPOSITION (Name of cemetery, gremetory or other place) Southern Memorial Gardens 11-3-95 Dunkirk												
examiner	22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, P.A., Owings, MI 23. PART I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Appr									, MD			
event, the medical	shock, or ha iMMEDIATE CAUSE (Fin disease or condition resulting in death)	part fullure. List	AC	UT (OR AS A CO	Ilne.	57				9			Interval Betw Onset and D
or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):												
	PART II. Other significant conditions contributing to death but not resulting in the RENAL FAILURE due to NEPHROSC										PERFORMED? 1 YES 2-NO 0		
any Inju	0 1 1			EA	hue i	To			515		-	CO DF	MPLETION OF CAU DEATH?
MEDICAL	0 1 1	FA	N	EA	hue 1 HR	10		RO.	5/5 ERTAIN	1 _ YES 2	-	CO DF	MPLETION OF CAUS
MEDICAL	DID TOBACCO U: 25. WAS CASE REFERRED TO EXAMINER?	SE CONTRIB	UTE TO CA	USE OF I	HRODEATH PLACE OF	YES [NO heck only o	E UNC	ERTAIN	1 YES :	-	CO DF	MPLETION OF CAUS DEATH?
, or item 23 shows any injur 1YSICIAN: MEDICAL	DID TOBACCO US	SE CONTRIB	UTE TO CA OSPITAL: Inpatient 2 280. DATE OF	USE OF I	HRIDEATH PLACE OF	YES [DEATH (C) A OT TIME OF	NO heck only o	UNC	ERTAIN	1 _ YES 2	NO	1 (MPLETION OF CAUS DEATH?
marked, or item 23 shows any Injur BY PHYSICIAN: MEDICAL	DID TOBACCO U: 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1	SE CONTRIB O MEDICAL Httl 1 (1) Pending investigation	UTE TO CA OSPITAL: Inpatient 2 28e. DATE OF (Month, Date of	USE OF E 26. ER/Outpatle INJURY sy, Year)	HRDDEATH PLACE OF ant 3 - DO 28b.	YES [DEATH (C) A OT OA OT INJURY	NO heck only o HED Nursing H 28c. M 1 [INJURY AT WORK?	neldence 8	Other (Specify)	NJURY OCC	1 {	NILBBLE PRIOR TO MPLETION OF CAU DEATH? YES 2 NO
28 is marked, or item 23 shows any InjunED BY PHYSICIAN: MEDICAL	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5	SE CONTRIB O MEDICAL H 10	UTE TO CA OSPITAL: Inpatient 2 28e. DATE OF (Month, Date of	USE OF E 26. ER/Outpatle INJURY sy, Year)	HRDDEATH PLACE OF ant 3 - DO 28b.	YES [DEATH (C) A OT OA OT INJURY	NO heck only o HED Nursing H 28c. M 1 [INJURY AT WORK?	neldence 8	Other (Specify) 28d. DESCRIBE HOW	NJURY OCC	1 {	NILABLE PRIOR TO MPLETION OF CAU
If item 28 is marked, or item 23 shows any Injur MPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1	SE CONTRIB D MEDICAL Pending Investigation Could not be determined	UTE TO CA OSPITAL: Inpatient 2 28e. DATE OF (Month, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devil	USE OF E 26. ER/Outpatle INJURY — atc. (Specify) my knowledge	PLACE OF at home, ta	YES [DEATH (C) DA OT TIME OF INJURY TIME OF INJURY	NO heck only o heak o heak only o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o h	UNC ne) lome 5 R NUNC NUNC NUNC NUNC NUNC NUNC NUNC NUN	neldence 8	Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street	NJURY OCC	OD DF 1 {	NILBBLE PRIOR TO MPLETION OF CAUSO DEATH? YES 2 NO
item 28 is marked, or item 23 shows any Injur PLETED BY PHYSICIAN: MEDICAL	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1	SE CONTRIB D MEDICAL Pending Investigation Could not be determined TIFYING PHYSICIAN ICAL EXAMINER: O	UTE TO CA OSPITAL: Inpatient 2 28e. DATE OF (Month, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devilding, Date of Devil	USE OF E 26. ER/Outpatle INJURY — atc. (Specify) my knowledge	PLACE OF at home, ta	YES [DEATH (C) DA OT TIME OF INJURY TIME OF INJURY	NO heck only o heak o heak only o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o heak o h	ET UNC ne) lome 5 Re INJURY AT WORK? YES 2 [ffice	ERTAIN Reldence 8 NO NO no, end due to red at the til	Other (Specify) 28d. DESCRIBE HOW City or Town, State, or the cause(e) and me me, data and place, as	NJURY OCC and Number of states and due to the	URED Or Rural Round od. ceuse(e) er Signed (MC	NILABLE PRIOR TO MPLETION OF CAUS DEATH? YES 2 NO Number, Number, Number, Number, Number, Number, Number, Number,

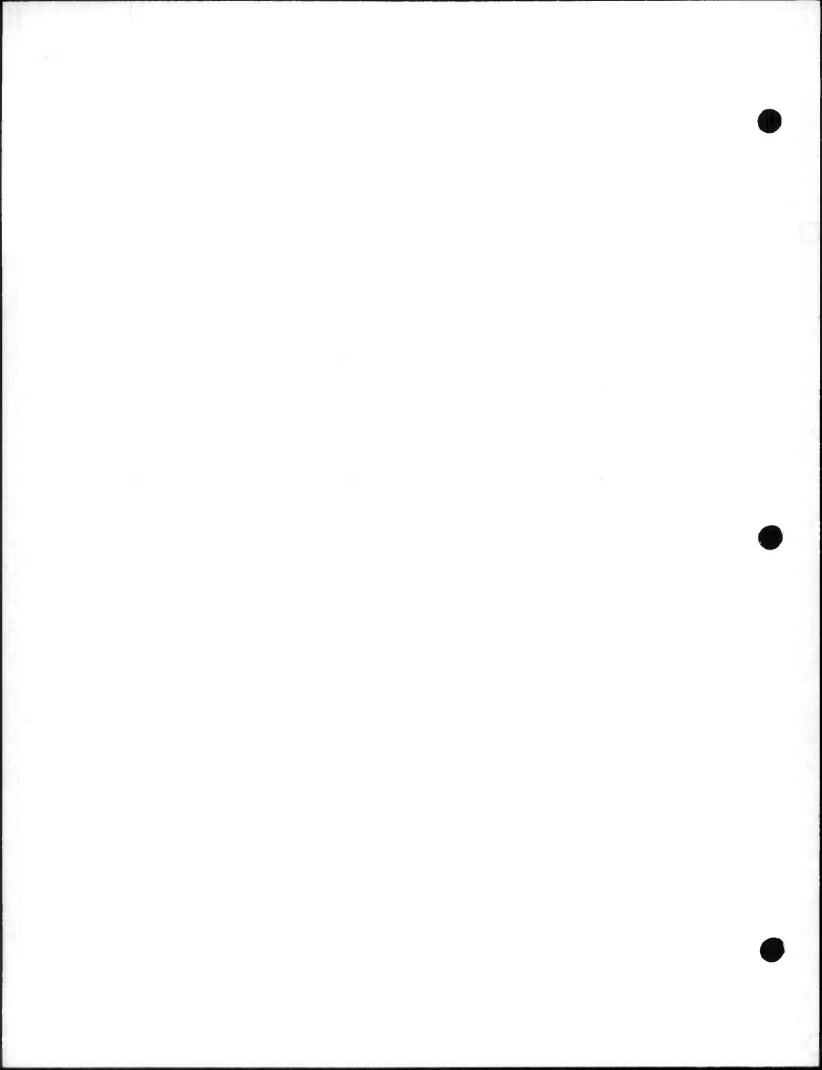
		505							34001
		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF ICATE OF		MENTAL HYGIEN REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)		OLITTI	TOATE OF	DEATH	2. DATE OF DEATH		3. TIME OF DEATH
		Charles Will	iam Wilson	S_{Σ}			Oct 26,199		9:10 P
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	in yrs. last birthday)	IF UNDER 1 YEAR	7	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTI	HPLACE (State or Foreign
2	1	236-20-7544	¹ X ^{M 2} □ F 7	4 YRS.	MONTHS DAYS	HOURS MIN.		.920 West	Virginia
should	_	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF DI		9c. COUNTY OF	
6,	DIRECTOR	Southern Marylan	<u>d Hospital C</u>	enter	Clin	ton		Prince	George
Pages 1) EC	10e. STATE 10b. COUNTY	,	10c. CIT	Y, TOWN OR LOCA	ATION			10d. INSIDE CITY
2€		Maryland Prin	ce George's		Oxon Hi	11			1 YES 2 NO
permit.	ERAL	10e. STREET AND NUMBER				01. ZIP CODE		10g. CITIZEN OF	44
- F		309 Brockton Roa				20745		United	States
020 physician. burial-transit	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 2 YES	U.S. ARMED	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)		E — American Indian, k, Whita, alc.
fing pt	B	3 Widowed 4 Divorced	WW II 1941-	1945		S 2 NO Specif		Whi	olfy:
en en en	8	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S			16b, KIND OF BUS	SINESS/INDUSTRY	LE
T. 6 .		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT us	work done during m se retired.)	nost of working	Self Em		
AND 2. The hospital of detached for	COMPLET	8th		Retire	d/ Secui	rity	Hospi		
SRE, MARYL 6 may be retained by 1 10r, page 5 should be 1ust be notified at	8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	
			illiam Wilso				e Caqar		
	ဝ	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow		
		Charles William W.					n Hill, Md		
		XXBurial 2 Cremation 3 Rame					,1995 20c. LO	inton, Md	own, Stata
Page al direc		21. SIGNATURE OF PHINERAL SERVICE LIC	EMILEE	esurrect	1.On Com	ND ADDRESS OF FA	Lee Fune	wal Home	Tno ((22
BALTIN after death. Pag y the funeral dir noval.		» ///x4/)/	Stack		01d 7	Alexandri	a Ferry Ro	ad Clin	ton, Md 2073
aft of or		23. PART I. Enter the diseases, or o	omplications that caused	I the death. Do r					Approximate
ST II I		shock, or heart fellure.	List only one cause on e	ech ilne.		out of a jung, and	ii aa coldige of loopi	ratory arrest,	Interval Between
% # P B		IMMEDIATE CAUSE (Final disease or condition	MASSIVE	0.0	0 - 20	h 1	1100	00/	Onset and Deeth
ted within 24 completely fill all, cremation, the		resulting in death)	DUE TO (OR AS A	CONSEQUENCE O	7:	1//	FITREII	ON	TOHY
		Sequentially list conditions,	HYPERT	ENSIL	IE A	THER	OSCIER	COTIC	LOVEARS
OX 68 be executed by the property of the prop	ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	7:				/
O. BOX ertificate be ing physician rgiene prior to other traur	임	CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE OF	- CO	LITA	PISE	ASE	S YEAR
O DE	E	that initiated events resulting in death) LAST	INTERN			T ('D) (3	-A.TEA:/		4
dea de	빙						RIERY	PISERS	
ORD: that the ned by the th and M and inly	18	PART II. Other algnificant condition				ng cause given in	Part I. 24s. ₩AS AN PERFOR		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	MEDICAL	PERIPHER				DISTA	1 TYES 2	NO NO	OF DEATH?
RECC w requires been signe nt. of Health			BSTRUC			NGDIS	ENST.		1 TES 2 NO
	N N	DID TOBACCO USE CONTE		F DEATH TE			10		
F VITAL SICIAN: The law certificate has the State Dep	Sic	EXAMINER? 1 YES 2 X NO	HOSPITAL:	atient 3 DOA	OTHER:	me 5 Rasidenca	8 C Other (Caralta)		
1. 0 0 23	Η̈́	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28c, IN	JURY AT	28d. DESCRIBE HOW II	NJURY OCCURED	
ON OF DING PHYSI After this c death with	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		YES 2 NO			
ATTENDING ECTOR: After s after death		3 Suicide 6 Could not be	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, a	treet, factory, offi	ca	281. LOCATION (Street a City or Town, State)	and Number or Rural I	Route Number,
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is mai		4 Homicide determined							
DIV TAL OR A PAL DIREC 72 hours	AP.	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSII	CIAN: To the best of my know	edge, death occurr	d at the time, dat	a and place, and due	to the cause(s) and men	ner as stated.	
HOSPITAL FUNERAL Within 72 I	COMPL	2 MEDICAL EXAMINE	R: On the basis of examination	and/or investigatio	n, in my opinion,	death occured at the	ilme, data and placa, an	d dua to the cause(s	a) and manner as stated,
TO THE HOSPI TO THE FUNER be filed within	BE (296. SIGNATURE AND TITLE OF CERTIFIER	leul	1	1, P.	29c. LICENSE NUM	-10.	29d. DATE SIGNED	4
W	1 400	100000				D 16	1150	►10/E	5/11995

31. DATE FILED (Month, Day, Year) NOV 0 7 1995

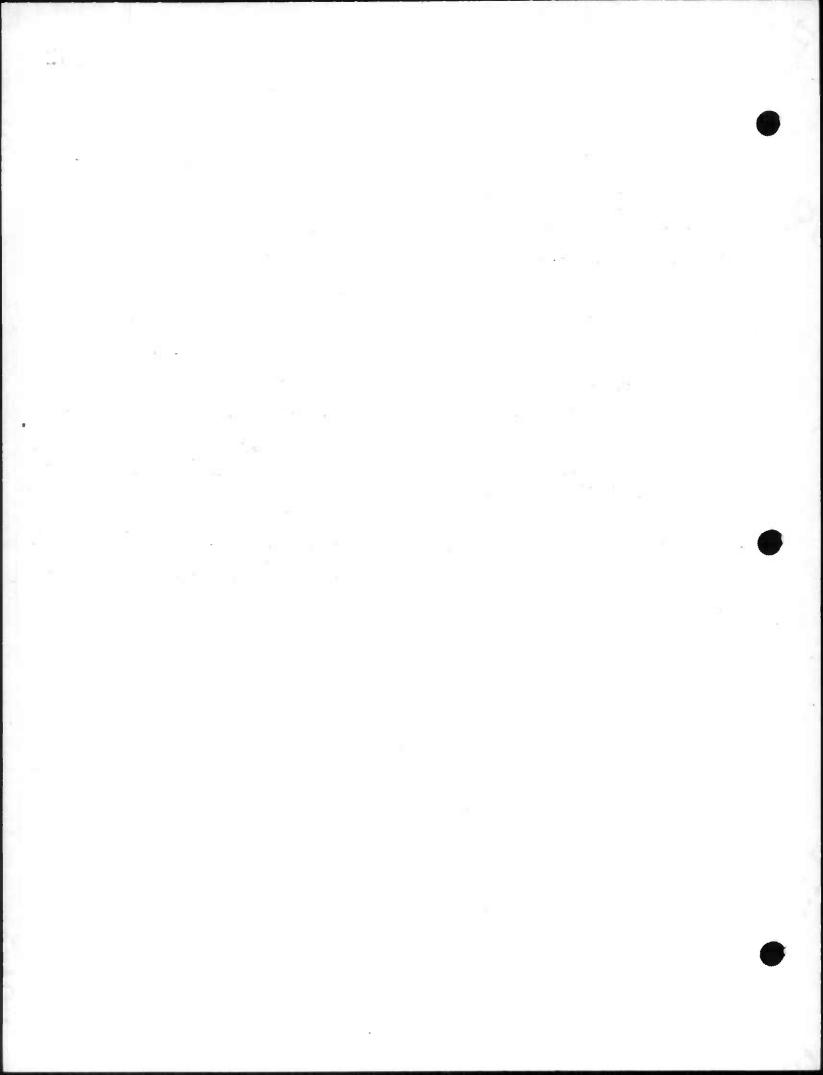
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jalia Dander Randall

2

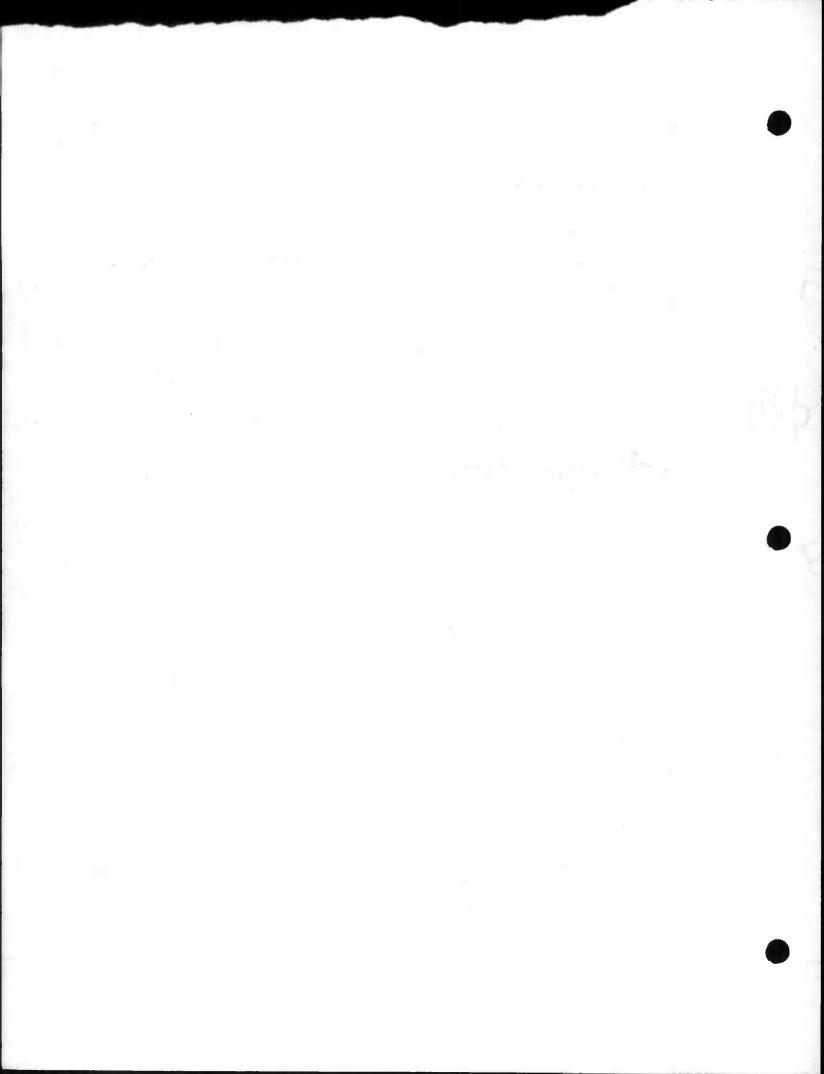


		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART			MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last) ROLAND 4. SOCIAL SECURITY NUMBER 5.		ELLS	F UNDER 1 YEAR	F UNDER 24 HRS.	2. DATE OF DEATH MONTH OUTMET 7. DATE OF BIRTH	3.19	3. TIME OF DEATH A 75 6 25 M BIRTHPLACE (State or Foreign
Should	۳.	220-07-9257 1 96. FACILITY NAME (If not institution, give street	XM 2 ☐ F	73 YRS. M	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) NOV 1, 19	921 N	Country) Iaryland OF DEATH
Pages 1, 2, 3	RECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	YIAND HOS	10c. CITY,	TOWN OR LOCAT		2)	PA	10d. INSIDE CITY
permit.	RAL DIR	Maryland Prince 100. STREET AND NUMBER 7319 Marlboro Pike	ce George's	FO	prestvil	. ZIP CODE 2074	17		1 D YES 2 XXNO OF WHAT COUNTRY? ed States
215-0020 attending physician. se as the burial-transit	BY FUNER		2. WAS DECEDENT EVER IN U. FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATE:	2 NO	If yes, spi	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	8 or No — 14.	RACE — American Indian, Black, White, atc. Specify:
21 alor for u	COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)		Give kind of working. Do NOT use Electri	rk done during mo. retired.)	ON st of working	Local	SINESS/INDUS	
YLA by the be det	TO BE COM	Edwin V. Wells, Sr					ME (First, Middle, Maiden E. Wyvill		
E, MA y be retain age 5 sho be notific		19a. INFORMANT'S NAME (Type/Print) Willa Doris Armentro 20a. METHOD OF DISPOSITION	205 81	7319 M	Marlboro	Pike, F		vn, State, Zip Co. e, Mar]	Lboro, MD 20/4.
ALTIMORE death. Page 6 may e funeral director, pa f.		1 N Burial 2 Cremation 3 Ramoval 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	from State Cemeter MOU	nt ^{em} caime	22. NAME AN	tery 11-6	1995 Up	per Mai eral Ho	rlboro, Marylar ome, Inc 6633 inton, Md 20735
d within 24 hours after of mpletely filled in by the cremation, or removal.		23. PART I. Enter the diseases, or comshock, or heart feiture. List IMMEDIATE CAUSE (Finel disease or condition resulting in death)	POST OR DUE TO (OR AS A CO	STRU DISEQUENCE OF):	CTIV	E P	NEUmo	NIA	Approximate interval Between Onset and Death
5, P.O. BOX 6870 death certificate be executed attending physician and con- ental Hyglene prior to burial, y, or other traumatic er	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):	LUNG	- ME	TASTA	MC	48hm.
signed by the Health and Me	MEDICAL C	PART II. Other significent conditions c	ontributing to death but i	not resulting in	the underlying	g ceuse given in	Part I. 24s. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
S ep t p s p	NAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.	PLACE OF DEATH		UNCERTAIN	1 🗆		
SICIAN: The certificate the State	PHYSICIAN:		OSPITAL: Vinpatiant 2 - ER/Outpatia 26a. DATE OF INJURY			e 5 🗆 Rasidenca	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	FD
ATTENDING PHYSICIAN: The ECTOR: After this certificate has after death with the State D 128 is marked, or Item:	D BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be datermined	(Month, Day, Year) 26e. PLACE OF INJURY — building, aic. (Specify)	At home, lerm, stre	M 1 WOI	RK? (ES 2 NO	28I. LOCATION (Street City or Town, State)	and Number or F	
TAL OR VAL DIRE	COMPLETE	29a. CERTIFIER (Check only	N: To like best of my knowledg						
TO THE HOSPITAL. TO THE FUNERAL Be filed within 72 I	H	29b. SIGNATURE AND TITLE OF CENTIFIEN	- PHYSI	CIAN.	тт пу оритол, о	29c. LICENSE NUM		29d. DATE SI	GNED (Month, Day, Year)
	0	30. NAME AND ADDRESS OF PERSON WHO CO SURESH PATE 31. DATE FILED, (Megito, Dev. Year)	Limp 75	101 501		TS RD \$	1302, C	LINTO	N. 20735
		NUV 0 7 1995	32. REGISTRARY SIGNATU	or hardall					



BALTIMORE, MARYLAND 21215-0020

		1 - STATE SEGISTRAR	TATE OF MARYLAND		TMENT OF		MENTAL HYGIEN	E 95	34883	
- 1		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
		June	Elai	ine	Wa	ddell	November 0		2:10 P. M	
				. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. Bi	IRTHPLACE (State or Foreign puntry)	
9		200 14 3/0/	□ M 2 💢 F 72	YRS.			Jan. 16, 1	1923	Ohio	
3 should	~	9a. FACILITY NAME (If not institution, give street				OR LOCATION OF DE	ATH	9c. COUNTY C		
N N	DIRECTOR	Physicians Memorial Hos	spital		La Plata			Char]	.es	
ges 1,		10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	ATION			10d. INSIDE CITY	
F. Z.	ā	Maryland St. Mar	y's	Med	hanicsv	ille			1 X YES 2 NO	
E de	ĭ.	10e. STREET AND NUMBER			-10	01. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
me burial-transit permit. Pages	FUNERAL	1200 Birch Court				20659		U.S	.A.	
uriai-r	F	1 Never Married 2V V Married	WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	X NO	If yea, a	pecify Cuban, Maxica		or No 14. F	RACE — American Indian, Bleck, Whita, atc.	
e e	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 🗆 YE	S 2 X NO Specify	r.		Specify: hite	
Se as	E	15. DECEDENT'S EDUCATION (Specify only highest grade come	ON 16s	DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BUS			
0		Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	Ilfe. Do NOT us	e retired.)	lost or working				
ie ched	COMPLET	12		Secre	tary				y Government	
at once.	_	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden			
e pa	BE	Whitten Allen 19a. INFORMANT'S NAME (Type/Print)		105 MAII INC	ADDRECO (Co	Faye Lane S (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
s should be detached for use notified at once.	2	James C. Waddell					inicsville.			
bage page		20a, METHOD OF DISPOSITION	20b, PL/		OF DISPOSITION (CATION - City of		
in by the runeral director, page removal. edical examiner must be		1V Buriel 2 Cremetion 3 Removel 4 Donation 5 Other (1997)	from State cemeters	nity M	emorial	Gardens	11/6 Wald	dorf. M	arvland	
iner		21. SIGNADITIS OF FUNERAL SERVICE LICENS	Thucker		22. NAME	AND ADDRESS OF FA	CILITY		7	
e runeral on I. examiner		Benjamin M. Mat	thews M-0065	8			eral Home		1 00004	
or removal		23. PART i. Enter the diseases, or comp					Waldorf N		Approximate	
De E		shock, or heart feilure. List IMMEDIATE CAUSE (Finel	only one ceuse on each	line.					interval Between Onaet and Death	
nation the		diseese or condition resulting in death)	COPD						YRS	
and completely filled to burial, cremation, or natic event, the mi			DUE TO (OR AS A CO	NSEOUENCE O	F):				14.	
burial atic	N	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING b. CLHF DUE TO (OR AS A CONSEQUENCE OF): Simple I of Ca							YRS	
the attending physician and c Mental Hygiene prior to buna njury, or other traumatic	CATIO								YRS	
ne pri	正	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF):							
Hygie or ot	E	resulting in death) LAST	COR PUL	mon	ACE				YRS	
d Mental	CE	PADT II Other cleatificant annulation of								
and N	SAL	PART ii. Other significant conditions or	ontributing to death but r	not resulting	in the underlyi	ng ceuse given in	PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
of Health at	EDIC,	10011					1 TYES 2	EXNO	OF DEATH?	
of H	Σ	DID TOBACCO USE CONTRIB	LITE TO CALISE OF I	DEATH YE	S X NO I	UNCERTAI			1 YES 2 NO	
Dept.	AN	25. WAS CASE REFERRED TO MEDICAL			TH (Check only on		101			
State	SICI		OSPITAL: Inpatient 2 ER/Outpaties	nt 3 🗆 DOA	OTHER:	me 5 🗆 Realderica	6 ☐ Other (Specify)		- 3	
th the	РНҮ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	IE OF 28c. II	JURY AT	28d. DESCRIBE HOW	NJURY OCCURE	D	
fter this eath with marked	ВУ	1 Natural 5 Pending 2 Accident Investigation	(Works, Day, Year)	- 113		YES 2 NO				
er de		3 Suicide 8 Could not be 4 Homicide datermined	28a. PLACE OF INJURY — i building, atc. (Specify)	At home, farm,	atreet, factory, off	lca	281. LOCATION (Street City or Town, State)	and Number or Re	ural Route Number,	
TECTOR Ins after In 28	ETE									
AL DIRE 72 hours 11 item	MPL	anal and	i: To the best of my knowledg							
ithin ANT:	OS	2 MEDICAL EXAMINER: O	in the beals of examination an	d/or Investigation	on, in my opinion,	death occured at the	Ilme, data and place, ar	nd dua to the car	use(s) and manner as stated.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by be filed within 72 hours after death with the State Dept. of Health and IMPORTANT: If Item 28 is marked, or Item 28 shows any in	BE	296. SIGNATURE AND TITLE OF CERTIFIER	· · · · · · ·			29c. LICENSE NUI	MBER	29d. DATE SIG	SNED (Month, Day, Year)	
2 8 2	2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH	(ITEM 27) (5	Print)	D-47849		111	5 73	
		Monika Lee, MD. 700 0				of Maryland	1 20602			
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATU	RE O	. watuul	المتر و عامل و ع	1_20002			
		31. DATE FILED (Month, Day, Year) NOV 0 7 1995	Julia Davides	n-Kardal	(



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be detached for use as the burial-transit

funeral director, page 5 should

completely

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attending physician

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I OF VITAL RECORDS, P.O. BOX 68760	equires
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO! 1. DECEDENT'S NAME (First, Middle, Last) 2 DATE OF DEATH 3. TIME OF DEATH WATSON October YEAR OHN 7:00-PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Mogth, Day, Year) 8768 Clinton 5.C. 89 1 M 2 - F 566 9s. FACILITY NAME (If not institution, giv 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2907 Fletcher Town Ro Bowle DIRECTOR MN PRINCE George's RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10h COUNTY INSIDE CITY LIMITS? 1 X YES 2 NO owie FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20 907 etc her 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerlo Rican, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 3 Wildowed 4 Divorced BIK II WW 1945 COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5 +) Abor Building once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle. OHN ANCY te notified 19a. INFORMANT'S NAME (Type/Print) 2 BOY WATSON WAShington D.L. 20017 pe 20a METHOD OF DISPOSITION
1 Disposition 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must Helery, cramatory or other plade) Veterrars Putpon Dod ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 4804 NIW E. JAMESE VANN WAShington DIC, filled in by the figure or removal. traumatic event, the medical 23. PART /. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Batwaan 0 Onset and Death **IMMEDIATE CAUSE (Final** cremation. disease Dr condition a. Generalized ATheroscleratic CardioNAScular Disease
Due to ion as a consequence of: reaulting in death) years - non-insulin dependent Mental Hygiene prior to burial, Diabetes mellitus -CERTIFICATION Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury 23 shows any injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST Health and Men PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? WAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 YES 2 NO certificate has been the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I PHYSICIAN: Dept. 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Hem State HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA 1 X YES 2 NO 4 ☐ Nursing Home 5 KReeldence 6 ☐ Other (Specily) the 10 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 X Natural 5 Pending Investigation 1 YES 2 NO After the В 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 69 6 Could not be DIRECTOR: /
hours after of
item 28 is COMPLETED 4 Homicide 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and my knowledge. FUNERAL I = 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, TO THE HOSPITA
TO THE FUNERA
be filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE & Bryen MD 25 October 29, 1995 DZ59 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 WISCONSIN AVE, Bethosda, Md.

31. DATE FILED (MONTH, Day, Year)

OCT 31 1995 July Division Resident 31. DATE FILED (Month, Day, Year)

OCT 311 31 1995

13. 2 2 2 1 .

BALTIMORE, MARYLAND 21215-0020	her death. Page 6 may be retained by the hospital or attending physician,	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	il examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death, Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

-	REGISTRAN				CENTIF	CALL	E OF	DEAL	l III		REG. NO.			
- 8	1. DECEDENT'S NAME (First, Middle,	Lost)								2. DATE	OF DEATH			3. TIME OF DEATH
	GLADYS	ESPE	TH	WAL	KER					OC.		26.	1995	10:33 a M
	4. SOCIAL SECURITY NUMBER	5. SE			s. last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH	6 U p	e. BIRTI	HPLACE (State or Foreign
	117-03-1626	1 🗆	M 2 ⊠ F		85 YRS.	MONTHS	DAYS	HOURS	MIN.	Octo	ber 1,	1010	Count	m ginia
	9a. FACILITY NAME (If not institution,	give street and	d number)		0,0	9b. CITY	, TOWN	OR LOCATION	ON OF D	-	UCI I,		JNTY OF D	
۳	Doctors' Commu	nitv	Hospit	a1										
5	RESIDENCE OF DECEDEN		Lanham Prince Geor					George S						
문	10a. STATE 10b. Co				10c. CIT	CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?
Doctors' Community Hospital Lanham Prince RESIDENCE OF DECEDENT 100. COUNTY 100. CITY, TOWN OR LOCATION										1 X YES 2 NO				
FUNERAL	10e. STREET AND NUMBER						10	. ZIP CODE	E			10g. CI1	IZEN OF	WHAT COUNTRY?
E	3636 Tyrol Dri	ve						2077	4			U.S	. A .	
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Se										14. RACI	E — American Indian,		
	1 Never Married 2 Married 3 Widowed 4 Divorced		ORCES? 1 [YES, GIVE WA					ecify Cube 2 2 NO			Rican, etc.)		Spec	k, White, atc.
ğ	3 🖾 Widowed 4 🗌 Divorced							3.6		•				Black
힏	15. DECEDENT'S (Specify only highest			164	DECEDENT'S	work done	CCUPATIO	ON ist of workin	ıa	16b	KIND OF BUS	INESS/IN	DUSTRY	
W	Elementary/Secondary (0-12)	1	ege (1-4 or 5 +)		Iffe. Do NOT us	e retired.)	9 1110	vrondii	-					
COMPLETED		1	4		Homemal	cer					Own H	ome		
8	17. FATHER'S NAME (First, Middle, Las	nt)						16. MOTH	IER'S NA	ME (First,	Middle, Malden	Sumame)		
BE	Andrew Brown									Will:				
2	19a. INFORMANT'S NAME (Type/Print)				19b. MAILING	ADDRESS	S (Street a	nd Number	or Rural	Route Numi	ber, City or Town	n, State, Zi	p Code)	
-	Sybil Walker-M	iller			3636	[yro.	l Dr	ive,	Spr	ingd	ale, M	ary1	and	20774
	20a. METHOD OF DISPOSITION	Removed to	nm State		ACE AND DATE	F DISPOS	SITION (Na			DAT				
	1 M Burlel 2 Cremetion 3 Removed from State 4 Donetion 6 Other (Specify) Arlington National Cem. 11/03/95 Arlington, Virginia										Virginia			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
Francis Gasch's Sons Funeral Home, P.A														
\dashv	23. PART i. Enter the diseeses	or compli		sen	a doubt. Do a	147	39 I	Balti	more	e Ave	Hyat	tsvi	ille,	MD 20781
- 1	shock, or haert feil	ure. List or	niy one caus	e on eech	iine.	ot enter	tha mo	ae or ayı	ng, suc	n es carc	nec or reap	ratory sr	rest,	Approximate interval Between
ı	iMMEDIATE CAUSE (Fine) disesse or condition		DIET	Imn	MIA	,								Onset and Death
ļ	resulting in death)	a			NSEQUENCE OF									5day.
_			DOE TO (C	JR AS A CUI	NSEQUENCE OF	·):								
RTIFICATION	Sequentially list conditions,	b	DUE TO (OR AS A COL	NSEQUENCE OF	n.								
¥ I	if sny, leeding to immedista cause. Enter UNDERLYING		(
트	CAUSE (Disesse or injury that initiated events	С	DUE TO (C	OR AS A COI	NSEQUENCE OF):								
	resulting in desth) LAST	V av												
핑		0												
A	PART ii. Other significant cond							ceuse g	iven in	Part i.	24a. WAS AN		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL	Atheroscerotic		ibvari	ular	- Dis	ears	<u></u>				1 YES 2	-		COMPLETION OF CAUSE OF DEATH?
	Azotemi	a									_ >			1 TYES 2 NO
HYSICIAN: M	DID TOBACCO USE CO		TE TO CAU	ISE OF D	EATH YE	S 🗆 I	NO [UNC	ERTAIN	NX				
<u> </u>	25. WAS CASE REFERRED TO MEDIC	AL.			PLACE OF DEAT									
<u> </u>	EXAMINER? 1 YES 2 NO		PITAL:	ER/Outpatier	N 3 □ DOA	OTHER		e 5 🗆 Ras	sidence	8 Othe	r (Specify)			
Ē	27. MANNER OF DEATH		8e. DATE OF II	JURY	28b. TIM	OF	28c. INJ	URY AT			CRIBE HOW IN	JURY OC	CURED	
2	1 Natural 5 Pending 2 Accident Investige	tion	(Month, Day	. ros/)	INJ	M		RK? (ES 2 _	NO					
ם מ	3 Suicide 8 Could no	2	8e. PLACE OF	INJURY - A	It home, farm, s	treet, fact	ory, office			28f. LOC	ATION (Street a	nd Numbe	r or Rural F	Route Number,
3	4 Homicide datermin		building, et	нь (эрвспу)						City	or Town, State)			
ן י	29e. CERTIFIER (Check only	HYSICIAN- T	o the heat of -	n knowlede	doub accur	el ad ab = ·	lma de	and =t	257.00	do ch		TOTO		
COMPLE) and manner so stated.
3						., my 0	prinort, O				arro prace, and	aua to ti	THE CHURO(A	y and manner ee stated.
N N	296. SIGNATURE AND THE OF CER		an					29c. LICE		MBER 1		29d. DAT	E SIGNED	(Month, Day, Year)
5 ∥	F1 0 0	1						リラ	23	101			0-6	1 -12
-	0 . NAME AND ADDRESS OF PERSON		1 .	OF DEATH	(ITEM 27) (Type,	Print)	الم ا	71	1	Č. 1 b. 4	1 M	D	7117	17 -1
	r 4. 12407 KY7	W.D	/			HV	L6 +1	1-1.	14	ur	e i in		201	0 / '
	31. DATE FILEO (Morith, Day, Year) QCT 3 0 19	QE 3	2 AEGISTRAD	S SIGNATUR	Kentuk									
- 10		JJ /	7											



Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w. T. 4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit permit. Be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR	1 . STATE STATE OF MARTILAND / DEFARIMENT OF REALITY AND MENTAL HIGHER								
1. DECEDENT'S NAME (First, Middle,	Last)		71112 01	527111	2. DATE OF DEATH 3. TIME OF DEATH				
DOROTHY	Hill WIL	LIAMS			OCTOBE	ER 26	1995	6 58P M	
4. SOCIAL SECURITY NUMBER 578-64-7332	5. SEX 6. AGE 5.		ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day Augus)	RTH 1942 1 27,	Count	HPLACE (State or Foreign	
9e. FACILITY NAME (# not institution. Prince Georges	give street and number) s General Hospi		b. CITY, TOWN C	erly	ATH	9c. 0 Pr	ince	Georges	
RESIDENCE OF DECEDER									
	Maryland Prince Georges 10c. CITY, TOWN OR LO							10d. INSIDE CITY LIMITS? 1 YES 2 NO	
100. STREET AND NUMBER 805 Bolboa	Avenue	t01	20743			States			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 Tyes IF YES, GIVE WAR OR D	If yes, sp	ENDENT OF HISPAN ocify Cuben, Mexical 2 X NO Specify	n, Puarto Rican		— 14. RAC Blec Spec	E — American Indian, ck, White, etc.		
15. DECEDENT (Specify only highes Elementary/Secondary (0-12)	S EDUCATION t grade completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	k done during ma etired.)	st of working	16b. KINI	O OF BUSINESS			
12th grade		Superviso	or Cust			Hotel:	_		
17. FATHER'S NAME (First, Middle, Li unknown				18. MOTHER'S NA Virgi		Hill		Sennett	
19a. INFORMANT'S NAME (Туре/Prin Ruben William		The second second second second		enue, Cap				and 20743	
20a_METHOD OF DISPOSITION 1 (ABurtel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Nov. 2, 1945) 20c. LOCATION - City or Town, State capacity, Crematory to pointer, Close) Mars-HIII Baptist Church Cemetery, Emporia, Virginia									
21. SIGNATURE OF AINERAL SERV	Waton Ang	Res	22. NAME A	o address of fa	CILITY Lati	ney's E	Tunera	1 Home	
shock, or heart fa	a, or complications that cause illure. List only ons cause on a		enter the mo	da of dylng, auc	h as cardiac	or respirator	y arrest,	Approximate interval Between Onset and Daath	
IMMEDIATE CAUSE (Final disease or condition reaulting in death)	Respira	tory for a consequence of:	ulure					14 DAYS	
Sequantially list conditions,	Rulmer		mbol	Sm					
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST	C. OUE TO (OR AS	A CONSEQUENCE OF):							
	d								
0	hizephoenia	out not resulting in	the undariyin	g causa given in		PERFORMEO?		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
						J 120 2 M		OF DEATH? 1 YES 2 NO	
	ONTRIBUTE TO CAUSE O				N 🗆 📗				
25. WAS CASE REFERRED TO MED EXAMINER?	HOSPITAL:		THER:			-			
1 YES 2 NO 27. MANNER OF DEATH	1 Inpetiant 2 ER/Out 28s. DATE OF INJURY	patient 3 DOA 4		ie 5 Rasidenca		ecify) BE HOW INJURY	COCCUBED		
1 Netural 5 Pendin 2 Accident Investig	(Month, Day, Year)	INJUR	RY WC	YES 2 NO	200. 02301110	JE 110W 1100M	OGGONEG		
3 Suicide 8 Could 4 Homicide determ	not be building, etc. (Spe	√ — Al home, farm, atro cify)	eet, factory, offic			N (Street and Nu wn, State)	imber or Rural	Route Number,	
One)	PHYSICIAN: To the best of my know							(a) and manner as stated.	
29b. SIGNATURE AND TITLE OF OR				29c. LICENSE NUI				O (Month, Day, Year)	
Prind	ler Sighr	10		D45	000			7-95	
D'SONC		60 Mit	chell.	ille Re	1, B	owie	MD	20716	
31. DATE FILED WORTH 0 2 YEAR	95 ANGISTRAR'S SIG	NATIOE CHARLES							

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68769

1. DECEDENT'S NAME (First, Middle, Last) Hattie Wheeler Robinson 2. DATE OF DEATH 3. TIME OF DEATH YEAR OCT AM 95 7. DATE OF BIRTH 1910 (Month, Day, Year) August 19, 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 577-52-3787 1 - M 2XX F 85 South Carolina Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9c. COUNTY OF DEATH Montgomery 9b. CITY, TOWN OR LOCATION OF DEATH Washington Adventist Hospital Takoma Park DIRECTOR 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY District of Columbia Washington 1 💢 YES 2 🗌 NO beath. Page 6 may be retained by the hospital or attending physician. Tuneral director, page 5 should be detached for use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1632 Eckington Place, N. E. 20002 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Married Black. ВY 3 ₩ Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY Izth grade College (1-4 or 5+) Licensed Practical Nurse Hospitals & Nursing Homes 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) George Robinson Washington Janie Love Simmons 젊 BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Angelica Davis Green (daughter) 1801 Cedrow Drive, High Point, North Carolina 27260 hours after death. Page 6 may be pe 20g: METNOD OF DISPOSITION
1 △ Burlel 2 □ Cremation 3 □ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Fort Tincoln Cemetery Oct. 30,1995 Brentwood, Maryland 4 Donation 5 Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY Latney's Funeral Home Shull Laluck 3831 Georgia Avenue, N.W.; Wash.D.C.20011 attending physician and completely filled in by the mal Hygiene prior to burlal, cremation, or removal. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fallure. List only one ceuse on each line Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) traumatic event, requires that the death certificate be executed with neumonia CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST the atter injury, PART II. Other aigniticant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL I Health and N 24s. WAS AN AUTOPSY shows any 1 HYES 2 NO OF DEATH? TES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN 🔀 has be Dept. PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER: 1 YES 2 THO Spatient 2 - ER/Outpatient 3 - DOA 4 Nursing Homa 5 Residence 8 Other (Specify) marked, or 27. MANNER OF DEATH 28s. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED this c 1 Natural 1 YES After t ВУ 2 Accident TO THE FUNERAL DIRECTOR: After be filed within 72 hours after deaf IMPORTANT: If item 28 is m 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated, (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 를 보고 1995 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Belongt

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

 BALTIMORE, MARYLAND 21215-0020 for doath Page 8 may be retained by the broadel or attacking physician

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

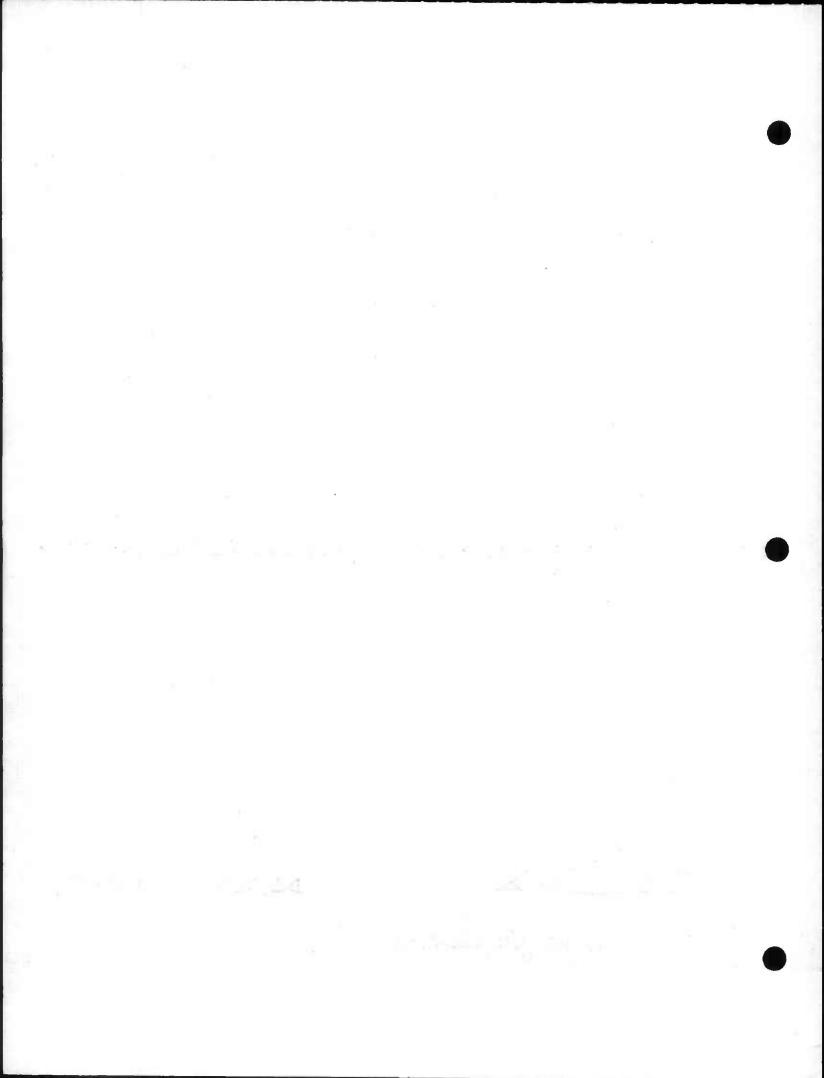
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTM CERTIFICATION CERIFICATION CERTIFICATION CERTIFICATION CERTIFICATION CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

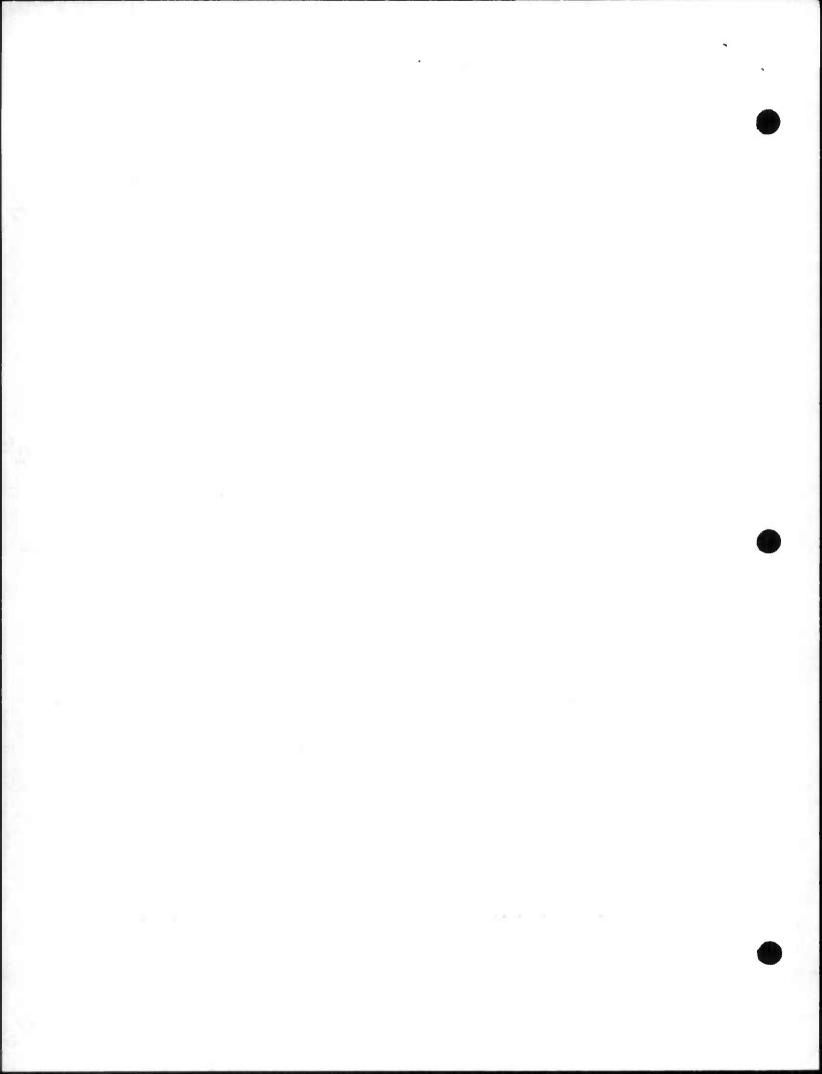
	REGISTRAR	CERTIF	ICATE O	F DEATH	REG. NO		
ļ	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH D	AY YE	3. TIME OF DEATH
	Robert		Wrote	,		1995	
		GE (in yrs. lest birthday)	MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) Feb 20,1	0.20	BIRTHPLACE (State or Foreign Country)
	218-24-3920 1X M 2 F	66 YRS.		7.5			Maryland
.	9a. FACILITY NAME (if not Institution, give street and number) Memorial Hospital at E	aston		OR LOCATION OF DE	EATH	9c. COUNTY	albot
DIMECTOR	RESIDENCE OF DECEDENT	aston	ь	13 (0 11		1 '	albut
	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LO	ATION			10d. INSIDE CITY
5	Maryland Talbot		Trap	ре			1 YES 2 NO
10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?							
UNEHAL	5189 Ocean Gateway			21673			US
5	11. MARITAL STATUS 12. WAS DECEDENT EVI	ER IN U.S. ARMED	13. WAS D	ECENDENT OF HISPAN specify Cuben, Mexica	IIC ORIGIN? (Specify Ye	or No- 14.	. RACE — American Indian, Black, White, etc.
2	1 Never Married 2 Married FORCES? A. D. V. 3 Widowed 4 Divorced Sept 48	R DATES 10		ES 2 NO Specify			Specify: White
			1				
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18e. DECEDENT'S (Give kind of v life. Do NOT us	work done during	TION most of working	16b. KIND OF BU	SINESS/INDUS	TRY
	Elementary/Secondary (0-12) College (1-4 or 5 +)	-	icemar	1	Powe:	r Comp	pany
COMPLE	17. FATHER'S NAME (First, Middle, Leet)			18. MOTHER'S NA	ME (First, Middle, Meiden	Sumame)	
	Arthur Teamon Wroten				dys Elze		
25	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street	at and Number or Rural i	Route Number, City or Tow	n, State, Zlp Co	de)
=	Rose S. Wroten	5189	Ocea:	n Gatewa	y Trappe	, Mar	yland 21673
	29e. METHOD OF DISPOSITION 1 A Burlet 2 Cremetion 3 Hamoval from State	20b. PLACE AND DATE	OF DISPOSITION	Name of			or Town, State
	4 Donatlon 5 Cher (Specify)	oMdry. orVeter	ans" Cer	netery	11/3 Hu	rlock,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE ACENSEE			AND ADDRESS OF FA	l Home, P.	٨	
	the wil home						yland 21613
	23. PARY I. Enter the diseeses, or complications that can						, Approximate
ı	ahock, or haert fellure. List only one cause of IMMEDIATE CAUSE (Finel	on aech lina.		,	-		Onset and Death
	disease or condition resulting in desth)	Jacobas.	a Car	marinet	ular D	V MO	10 Years
	DUE TO (OR	AS A CONSEQUENCE O	F):	1000000000			
Z	Sequentially list conditions,						
CERTIFICATION	If any, leading to immediate	AS A CONSEQUENCE O	F):				
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	AS A CONSEQUENCE O	n.				
=	that initiated events resulting in deeth) LAST		• •				į
<u></u>	d						
4	PART II. Other algnificant conditions contributing to dea	th but not reaulting	in the underly	ing cause given in	Part I. 24a. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
DICAL					1 YES :	2 740	OF DEATH?
							1 TYES 2 NO
Ë	DID TOBACCO USE CONTRIBUTE TO CAUSI				N 🔯		
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEA	OTHER:	10)			
S	YES 2 NO 1 Inpetient 2 ER		4 - Nursing H	ome 5 - Residence			
- 1	27. MANNER OF DEATH 1 C Netural 5 □ Pending 28a. DATE OF INJU (Month, Day, Ye		JURY	INJURY AT WORK?	28d. DEŞCRIBE HOW	INJURY OCCUP	RED .
E	2 Accident Investigation	JURY — At home, ferm,		YES 2 NO	28f. LOCATION (Street	and Number or	Sural Soute Number
3	3 Suicide a Could not be determined 208. PLACE OF IN. building, etc.	(Specify)	streat, ractory, o	ilica	City or Town, State		nural noute Number,
COMPLETED	29s. CERTIFIER						
Z	(Check only one) 2 MEDICAL EXAMINER: On the best of axamin						
3			on, an my opinion			,	
监	SHP BIOHA UNE AND TITLE OF CHARLER			29c. LICENSE NUI	MBER		IGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE O	F DEATH (ITEM 27) (3mg	Print)	BOLY	167	14	11175
- 1	The state of the s			Tooks	MD 2160	1	
	L. Thomas Divilio 40	4 Marvel	Ct.	Easton,	MD 2160:	L	
		4 Marvel	Ct.	Easton,	MD 2160.		



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

		***************************************				VEITIII	IVAI		DEATI		-	IEG. NO.			
		1. DECEDENT'S NAME (First, Mi	70 -						_		2. DATE OF MONTH	DA		YEAR 3	. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	Bess	5. SEX	A 40E //-			Ward			OCTO		23		10 45 PM
		217-09-628		1 M 2 F		yrs. lest birthday)	MONTHS	R 1 YEAR	HOURS 24	MIN.	7. DATE OF I	y, Year)		Country)	ACE (State or Foreign
should		9a. FACILITY NAME (If not institu	_	21	86	0 1113.	ah CIT	V TOWN	OR LOCATION	LOF DE	Oct.	7,19		Mary J	
3 kg	<u>د</u>	5604 Padao						lin		OF DE	AIR			r. George	
1, 2,	ECTOR	RESIDENCE OF DECE	,											. 000	rge
Pages	H.		b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION					1	Od. INSIDE CITY
ji. P	DIR	Md.	Wor	cester			Sn	ow 1	Hill					1	YES 2 NO
t permit.	FUNERAL	10e. STREET AND NUMBER						10	of. ZIP CODE				10g. CIT	IZEN OF WH	AT COUNTRY?
ian. transi	R	426 S. C	Churc							218			L.,	U.S	
DZU physician. burial-transit		1 Never Married 2 Ma	rried	12. WAS DECEDEN	YES	2 X NO	13.	If yes, s	CENDENT OF pecify Cuban,	Mexican	, Puerto Rice	pecify Yea n, etc.)	or No-	14. RACE - Black, \	- American Indien, White, atc.
	A	3 Widowed 4 Divorce	d	IF YES, GIVE V	AR OR DATE	ES		1 TYE	S 2 🙀 NO	Specify:				Specify:	rule di tere
attending se as the	COMPLETED	15. DECEDE (Specify only his	ENT'S EDUC	ATION	1	6a. DECEDENT'S	USUAL (OCCUPATI	ION lost of working		16b. KJP	D OF BUS	INESS/IN	DUSTRY	white
Z1Z1		Elementary/Secondary (0-12)		College (1-4 or 5	+)	life. Do NOT u	se retired.)	aunng m	osi or working		Sno	ow H	i11	Sewi	.ng
AND 21 he hospital or detached for u	M M	9				Seamst	res	s			FA	ctor	У		
4 2 5 E	8	17. FATHER'S NAME (First, Middle Otho Grif	. ,								ME (First, Midd				
ed by the ulid be o	H										Ste				.tn
retained 5 should notified	2	19a. INFORMANT'S NAME (Type Norris Wa							and Number or						725
Page		20a. METHOD OF DISPOSITION			205 8	LACEANDDATE				CL.		_			
BALIIMOKE, after death. Page 6 may be noval. cal examiner must be is	l i	XXBurial 2 Cremation 4 Donation 5 Other (Sp	3 🗆 Remo	val from State	cemete	ery, crematory or o	ther place	J			DATE			City or Town	
Page al dire		21. SIGNATURE OF FUNERAL S		INSEE	150	.Paul			ND ADDRESS	OF FAC	YTUR	Ma:	rlor	ı, Md	•
AL I IN death. Pag funeral dis examiner		Matri		1 11	en				Denn:	is	Funer	al 1	Home	2	
Es after d removal.		23. PART I. Enter the dise		molloctions the	_										1,Md.2186
filled ir ion, or		ahock, or hear IMMEDIATE CAUSE (Final disease or condition	t fellure. L	iet only one ceu	se on eac	h line.									Approximate interval Between Onset and Death
ted within 24 completely fill fal, cremation, event, the		resulting in death)		DUE TO	OR AS A C	CA,	NCE Di	ER	Wilh	/	NETA	STA	212		FEWYRS
executed and com to burlal, matic ex	z		- b												
4 8 2 E	RTIFICATION	Sequentially list condition if any, leading to immedia	te	DUE TO	(OR AS A C	ONSEQUENCE O	F):								
	<u>S</u>	ceuse. Enter UNDERLYING CAUSE (Disease or injury	1 c	DUE TO	(00.10.10										
certificate ding physical sygiene principle.	崑	that initiated events resulting in deeth) LAST		DUE TO	(OR AS A C	ONSEQUENCE O	F):								
L E 5 - 0	병		d	·											
E 65 E	- 91	PART II. Other significent		1				nderlyin	g ceuse giv	en In F	Part i. 24	. WAS AN			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
7 5 8 5 5	EDICAL	CONGESTIV		HEAR		AIME	6				1(YES 2		C	OMPLETION OF CAUSE F DEATH?
requires been signe of Health	WE	KENA		INSUA			_		^						TYES 2 10
AL KE he faw requ has been bept. of i		DID TOBACCO USE		IBUTE TO CA					UNCE	RTAIN					~
N: The famicate has State Dept	SICIAN:	25. WAS CASE REFERRED TO M EXAMINER?	EDICAL	HOSPITAL:	26.	. PLACE OF DEA	TH (Check)						
SICIAN: The certificate In the State I, or Item	×S	1 YES 2 NO		1 Inpetient 2			4 🗆 Nu	raing Hon	ne 5 Reald	_					
수 등을 할	PHY	1 Natural 5 Pen	iding	28a. DATE OF (Month, D		28b. TIN	IE OF IURY	W	JURY AT ORK?		28d. DESCRI	BE HOW IN	JURY OC	CURED	
After death	E E	2 - 0.114	stigation	28e. PLACE O	F INJURY -	At home, term,	street tec		YES	\rightarrow	281, LOCATIO	N (Ctmat a	and Adversaria	and Charact Charact	
TTEN TOR:	TED	_ 0 000	ild not be ermined	building,	atc. (Specify))	otivet, tec	nory, orne			City or To	wn, State)	na Number	OF MUTBL MOU	te Number,
DIRECT PORTS	"	29a. CERTIFIER CERTIFY	ING PHYSIC	IAN: To the best of	my knowled	ne deeth seem	and on the	al— - d-a				T			
TO THE HOSPITAL OF THE FUNERAL (DE FIED WITHIN 72 h	COMPLET														nd manner as stated,
HOSF FUNE withir		296. SIGNATURE AND TITLE OF						opinion, (praca, and			
THE fled POR	8	1/20 al	A						29c. LICENS	SE NUMI	443	6	29d, DAT	E SIGNED M	onth, Day, foar)
P P 8 \$	유	30. HAWE AND ADDRESS OF PE	RSON WHO	COMPLETED CAUS	SE OF DEATH	H (ITEM 27) (Type	Print)			-	. ()	0	-	10/2	-7/10
	10	Ashvin J. P						Road	Suite	20)7 Wal	dorf	Ма	206	502
	10	31. DATE FILED (Month, Day, Year	7)	32 REGISTRA	R'S SIGNATI	URE					TIOLE	WL I	PAU	200	.02
		OCT 261	995	Julia De	milemy	Rudali									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR

	REGISTRAR		CERT	FICATE O	F DEATH	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)	_				2. DATE OF DEATH	YOOF YEAR	3. TIME OF DEATH			
3	MARGARET 4. SOCIAL SECURITY NUMBER 5	F.		LCOTT		oct. 28,1		9:15 PM M			
	212-16-7524	□ M 2 💢 F	AGE (In yrs. lest birthda 99 YRS	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) FEB . 28, 1	1896 MŽ	RTHPLACE (State or Foreign untry) ARYLAND			
DIRECTOR	9a. FACILITY NAME (If not institution, give stree MERIDIAN—CORSIC		5		9b. CITY, TOWN OR LOCATION OF DEATH CENTREVILLE QUEEN A						
EC	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY										
	MARYLAND QUEEN 106. STREET AND NUMBER	ANNE'S		CENTRI	VILLE			1 XYES 2 NO			
FUNERAL	205 ARMSTRONG ST				101. ZIP CODE 10g. CITIZEN OF WH USA						
ВҰ	11. MARITAL STATUS 1 Never Married 2 Married XX Widowed 4 Divorced	2. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 X NO	RMED NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerlo Rican, etc.) 14. RACE—Black, WI 1 VES 2 NO Specify: Specify:							
COMPLETED		ION inpleted) Catlege (1-4 or 5+)	16e. DECEDEN (Give kind life. Do NO	of work done during use retired.)	most of working	16b. KIND OF BUS					
OMP	12 17. FATHER'S NAME (First, Middle, Last)			TEACH			EDUCA	ATION			
BE CC	JOSEPH FESMYER					Y CATHER	U - 22 - 2	RPER			
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town					
	MARGARET W. SEI	TRA						E, MD 21617			
	XXBurial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)		CHESTER	FIELD (CEMETERY	11-1 CEN	CATION — CRy or VTREVI				
	21. SIGNATURE OF FUNERAL SERVICE LICENS			NEV		ERAL HOME	•				
	23. PART I. Enter the diseases, Dr corr										
	ahock, or heert feilure. List iMMEDIATE CAUSE (Fine) disease or condition	t only one cause	on eech line.			ii as csidiec or respi	ratory arreat,	Approximate interval Between Onset and Death			
ŀ	resulting in death) a	DUE TO (OR	AS A CONSEQUENCE	ermon	<u>~</u>			duly			
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ÄŢ	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A CONSEQUENCE	OF):							
CERTIFICATION	CAUSE (Disease or Injury that initieted events resulting in death) LAST	DUE TO (OR	AS A CONSEQUENCE	OF):							
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	PART ii. Other aignificent conditions c	ontributing to des	ath but not reaultin	g in the underly	ing ceuse given in	Part I. 24s, WAS AN. PERFOR		4b. WERE AUTOPSY FINDINGS			
DICAL	1 gren	71 4				1 TES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
ME	DID TODA GGO HIGE GOALEDIA							1 - YES 2/1 NO			
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL	UTE TO CAUS		YES LI NO							
SICI	EXAMINER?	OSPITAL:	VOutpatient 3 □ DOA	OTHER:		a 🗆 au 🗥					
PHYSICIAN:	27. MANNER OF OEATH	26a. DATE OF INJI (Month, Day, Y	URY 26b. 1	IME OF 28c. I	ome 5 Residence	28d. DESCRIBE HOW IN	JURY OCCUREO				
ВУБ	1 Natural 5 Pending 2 Accident Investigation			M 1	VORK? YES 2 NO						
3 Suicide 4 Homicide 5 Could not be determined 5 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								al Route Number,			
<u> </u>	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL	N: To the best of my	knowledge, death occi	irred at the time, d	its and place, and dus	to the cause(a) and men	ner as stated.				
S I	one) 2 MEOICAL EXAMINER: C	on the basis of exami	ination and/or investiga	tion, in my opinion	death occured at the	time, data and place, and	d due to the ceus	e(a) and menner as stated.			
8	296. SHOWATURE AND TITLE OF CENTIFIER	S			29c. LICENSE NUI	MBER (4) (6)	29d. DATE SIGN	ED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO CO	7 . ~	OF DEATH (ITEM 27) (7)				, , ,	41//			
	31. DATE FILED (Month, Day, Year)	2108		uto Dr	ive (hote v	NO 91	618			
		32. REGISTRAR'S									

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		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	EALTH AND	MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) ALBERTUS			WHITE		2. DATE OF DEATH MONTH November	3°, 1995°	3. TIME OF DEATH 12:34 A M	
pin		4. SOCIAL SECURITY NUMBER 217-10-7076	1 🖾 M 2 □ F 86	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		.908	RTHPLACE (State or Foreign buntry) MARYLAND	
2, 3 should	стов	99. FACILITY NAME (If not institution, give at MEMORIAL, HOSPITA) RESIDENCE OF DECEDENT	,		Ob. CITY, TOWN C	DR LOCATION OF O	EATH	9c. COUNTY C	EGANY	
. Pages 1,	DIRECT	10a. STATE 10b. COUNTY			Y, TOWN OR LOCAT UMBERLAN	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
n. Insit permit	FRAL	100. STREET AND NUMBER 209 POTOMAC STREE	ET		101	21502		U.S.	OF WHAT COUNTRY?	
215-0020 attending physician. se as the burial-transit permit. Pages	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	24 4NO	If yes, sp	ENDENT OF HISPAI ecity Cuben, Mexica 2 NO Specifi	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	6	ACE — American Indian, Black, White, etc.	
2127 al or att	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	life Do NOT use entired)						
YLA by the be der	BE CON	17. FATHER'S NAME (First, Middle, Last) JOHN ADAM WHITE								
A 8 e	101	19e. INFORMANT'S NAME (Type/Print) RUTH WHITE		199b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 POTOMAC STREET CUMBERLAND MARYLAND 21						
e 6 m		20a, METHOD OF DISPOSITION 1 A suriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FURERAL SERVICE LEC	camete SUI	PLACE AND DATE (lery, cremetory or o NSET CEI		OV 10 19 ND ADDRESS OF FA	95 CUME	SERLAND	MARYLAND	
BALTIN irs after death. Pag in by the funeral di femoval.		Dale L.	erutt		404 D	ECATUR S	FUNERAL F TREET CUME	BERLAND	MARYLAND	
with hours with creation or referrent the medi		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) BLECTROMECHANICAL DISSOCIATION DUE TO (OR AS A CONSEQUENCE OF):								
P.O. BOX 68 th certificate be executed physician and in Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list conditions, if sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): C. CORONARY HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): d							
L RECORDS, P law requires that the death as been signed by the attent Popt. of Health and Mental H 23 shows any injury, or	MEDICAL CI	PART ii. Other significant conditions	s contributing to death but	t not reaulting	in the underlying	g csuse givan in	Part I. 24s. WAS AN PERFO	RMEO?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 KG NO	
TAL The la	PHYSICIAN: 1	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			S NO C TH (Check only one)	UNCERTAIN	N D			
OF HYSIC his cet with th		1 YES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending	1. Inpatient 2 ER/Outpeti 26e. DATE OF INJURY (Month, Day, Year)	26b, TIM	4 Nursing Hom E OF 28c. INJ URY WO		6 Other (Specify) 28d. OESCRIBE HOW	INJURY OCCURED)	
DIVISION OR ATTENDING P DIRECTOR: After thours after death item 28 is mar	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify,	- At home, ferm, s			281. LOCATION (Street City or Town, Stete	end Number or Ru	rai Route Number,	
DI TAL OR VAL DIRE 72 hours If item	COMPLETED		CIAN: To the best of my knowled R: On the bests of exemination e						se(s) and menner as stated.	
TO THE HOSP! TO THE FUNE TO THE FUNE TO THE FUNE TO THE FUNE	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	DBALL +	1. D_		D23334	ABER		nber 8th 95	
Mus		Dr. Dinesh Shah 31. DATE FILED (Month, Day, Year)	Johnson Heig	hts Med		lding C	umberland	, MD. 2	21502	
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last) CHRISTINA	BARBARA	WAMPLER		2, 0	DATE OF DEATH	1995	3. TIME OF DEATH 5:45 A M			
	4. SOCIAL SECURITY NUMBER 214 07 3926 8e. FACILITY NAME (# not institution, give:	1 - M 2 1 F	BO YRS. MONT	NOER 1 YEAR IF UNDER HB DAYS HOURS	24 HRS. 7. C	ATE OF BIRTH Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country) MARYLAND 9c. COUNTY OF DEATH				
	SACRED HEART HO		C		ALLEGANY						
		108. STATE 106. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND ALLEGANY FROSTBURG									
	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF W 12704 VALE SUMMIT ROAD, SW 21532 U.S.A										
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 X NO	13. WAS DECENDENT Of If yes, specify Cube 1 TYES 2 NO	n, Mexican, Pu		Blee	4. RACE — American Indian, Black, White, etc. Specify: WHITE			
	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINE OPERATOR CELANESE CORP.							000			
	17. FATHER'S NAME (First, Middle, Last) JAMES H. SCOTT, S	SR.	THOMINE O	16. MOTI		First, Middle, Malden S					
JAMES H. SCOTT, SR. 190. INFORMANT'S NAME (Type/Print) WILLIAM EVERETT WAMPLER 12704 VALE SUMMIT ROAD, SW, FROSTBURG, MD 21532								MD 21532			
	20s. METHOD OF DISPOSITION 1 CRUMEN 2 Crementor 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGN DURE OF DISPOSITION 20b. PLACE AND DATE Of DISPOSITION (Name of cemelery, cremelory or other place) FROSTBURG MEMORIAL PARK 11/4/95 FROSTBURG, MD 21532 22. NAME AND ADDRESS OF FACILITY										
	· Mariley	MA	uvers/	SOWERS FUN 60 W. MAIN	ERAL H	IOME, P.A FROSTBUR	G, MD 2	1532			
	23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Liet only one ceuse on	each line.	1	4		atory arreat,	Approximata Interval Between Onset and Desile 24-36%			
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS	A CONSEQUENCE OF):		-	sis Signor	id	7-84'			
	that initiated events resulting in death) LAST	d. Due to (or as	a consequence of:	sis		V		1			
	PART II. Other significent condition		but not reculting in the		jiven in Part	24a. WAS AN A PERFORM 1 — YES 2	AED?	Ib. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO			
	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (C		ERTAIN [3					
	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Home 5 Research		Other (Specify) 1. DESCRIBE HOW IN	JURY OCCURED				
	2 Accident Investigation 3 Sutclide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Stele) 28f. LOCATION (Street and Number or Bural Route Number, City or Town, Stele)										
	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, end due to the cause(s) and manner es stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(e) end menner es stated.										
		ucus m		DI	PATC	1		BER 1, 1995			
	30. NAME AND ADDRESS OF PERSON W VINCENT, CLARENCE	, M.D. 909-E	SETON DRIV		AND, M	D. 21502					
	31. DATE FILES (MONTH) Day, Year, 1995	July a grant s sic	hardail								

BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS,	OCTAL OR ATTENDIAL DUNCHOLASS. The
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DIVISION OF VITAL RECORDS, P.O. BOX 6876C

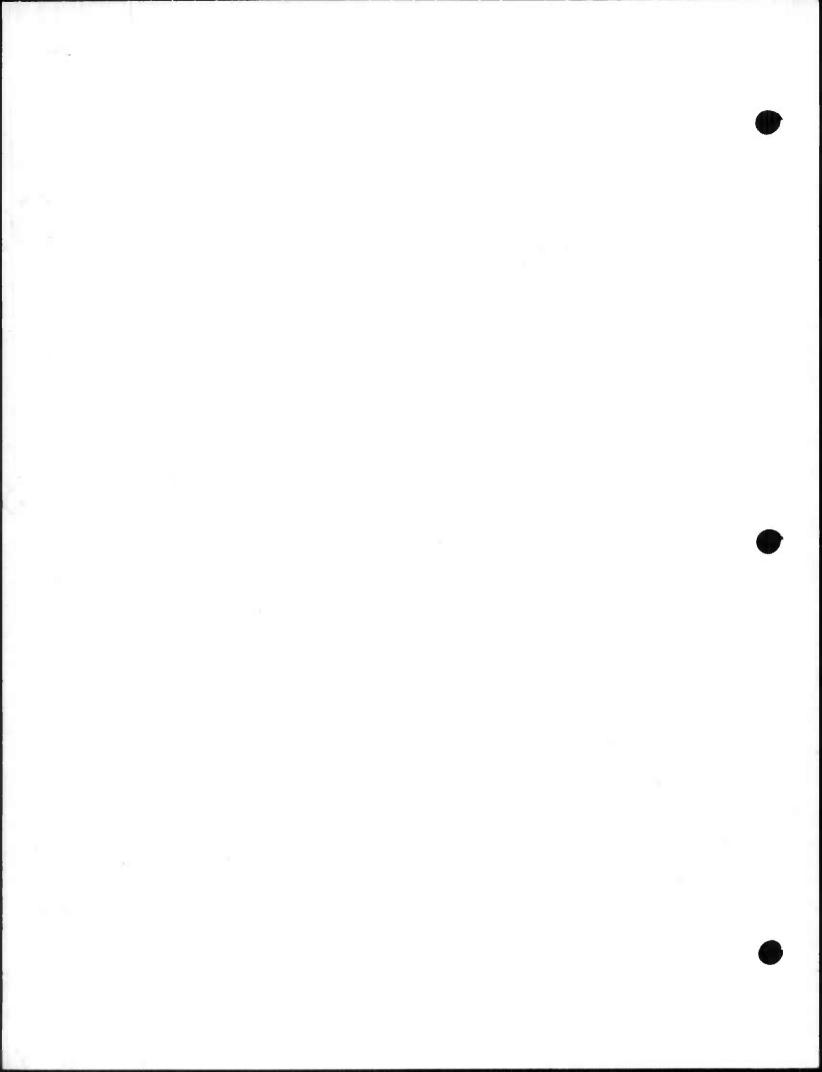
10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE

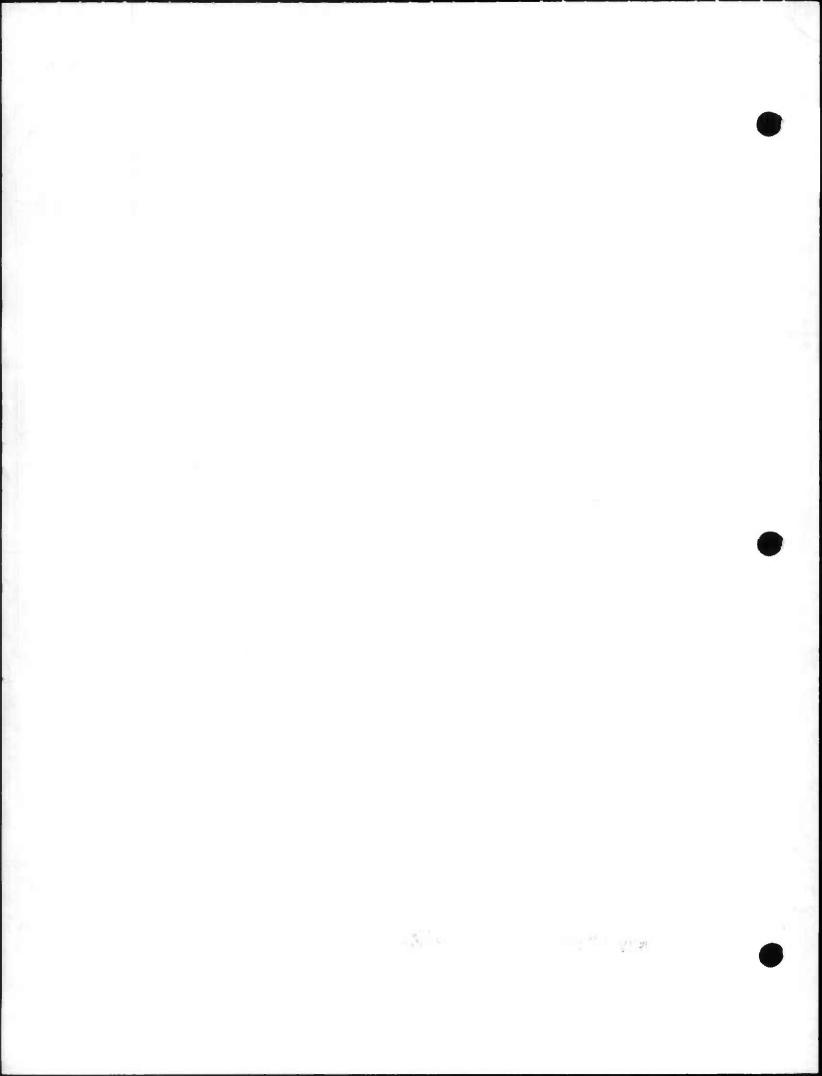
	REGISTRAN			FULL	ICALE	JF DEA		REG. I	10.		
	1. DECEDENT'S NAME (First, Middle, Last)				_			MONTH DAY YEAR			3. TIME OF DEATH
1		JAMES T.		WATSON		October 30,1995		95	11:25 a w		
JR.			6. AGE (In yrs. le:	. AGE (In yrs. last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.		7 DATE OF BIRTH		8. BIRTHPI	LACE (State or Foreign
	232-60-8031	1 💢 M 2 🗆 F	54	YRS.	MONTHS D	AYS HOURS	MIN.	Sept. 25	,1941	WEST	VIRGINIA
	9e. FACILITY NAME (If not institution, give st	reet end number)			9b. CITY, TO	WN OR LOCAT				INTY OF DEA	
	Memorial Hospita	1			C,,,	nhorla:	nd				
K	RESIDENCE OF DECEDENT				Cumberland Allegany						
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR L	OCATION			_	1	Od. INSIDE CITY
ā	WEST VA HAM	MPSHIRE		L	EVELS	LIMITS				LIMITS?	
4	10e. STREET AND NUMBER					10f. ZIP COD	DE		10g. CI1		AT COUNTRY?
FUNERAL	HC 60, BOX 32 FRENCH'S RO					254	31			.S.A.	
2	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM				13. WAS	DECEMBENT	OF HISPAN	IC ORIGIN? (Specify			- American Indian,
	1 ☐ Never Married 2 Merried FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES				If ye	s, specify Cub	an, Mexicar	n, Puerto Rican, etc.)	100 OI NO	Black, 1	White, atc.
ВУ	3 Widowed 4 Divorced	IF TES, GIVE W	AN ON DATES		''	TES 2 K NO	Specify			Specify:	WHITE
유	15. DECEDENT'S EDUC	ATION	16a. DE	CEDENT'S	USUAL OCCU	PATION		16b. KIND OF	BUSINESS/IN	DUSTRY	
ы	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +	(G	ive kind of v . Do NOT us	work done durir se retired.)	g most of work	ing				
7	12			ST.	PLANT	MANA	GFR	KOPP	ERS	INDUS	STRIES
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, Maid	en Sumama)	·	
	DON B. WATSON							\ L. JOH			
BE	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS /Sr			loute Number, City or		in Codel	
2	RITA WATSON			1C 6	0. BO	X 32	- 1 F	EVELS, W	V 2	5431	
1	20a. METHOD OF DISPOSITION		- T		OF DISPOSITIO						10-10-2
	1 X Buriel 2 Cremetion 3 Remo	rval from State	cemetery, cre	matory or o	EMETI	n (Name or	11	1 /-		City or Town	
	21. SIGNATURE OF FUNERAL SERVICE LICE	FNSEF	LEVE	L3 (E AND ADORE			_ E V E L	S, W	V
ĺ	M / / / / / 7		,		UP	CHURC	H FI	INFRAL H	OMF.	INC.	
	March 1). b	schuld			P.	O.BOX	126	INERAL H	HBY,	WV 2	7719
	23. PART i. Enter the diseases, or &	omplications that	caused the de	ath. Do r	not anter the	moda of dy	ring, auch	as cardiac or re	apiratory ar	reat,	Approximata
	anock, or haart failure. List only one cause on each line.								Interval Between Onset and Death		
	disease or condition										
i	resulting in death) a. Advanced Multiple Myeloma Due to (or as a consequence of):										
2	h Hypercalcemia 6 months										
힐	Sequentially flat conditions, If any, leading to immediata							0 monens			
8	cause. Enter UNDERLYING										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d											
	resulting in death) LAST										
ö											
EDICAL	PART II. Other aignificant conditions	contributing to	daath but not r	asulting I	in the undar	iying cauaa	givan in i	Part I. 24s. WAS	AN AUTOPSY ORMED?		VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
8 1								1 _ YES	200 NO	C	OMPLETION DF CAUSE F DEATH?
ME								YES 2 NO			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DINCERTAIN										
¥ I	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
Sic	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	Home 5 3	esidence i	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TiM	E OF 280	. INJURY AT		28d. DESCRIBE HOV	V INJURY OC	CURED	
7	1 Natural 5 Pending	(Month, De	ty, Year)	UINJ	URY 1	WORK? YES 2	NO				
BY	2 Accident Investigation 28s PLACE OF IN HIDV. At home form stood feeting office						te Number				
逆	S Could not be determined 8 Could not be determined building, etc. (Specify) 8 Could not be determined building, etc. (Specify)										
"	29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the heet of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first of the sent of my knowledge deeth occurred at the first occurred at the f										
₹ I				owledge, deeth occurred at the filme, date and place, and due to the cause(s) end menner as stated.							
COMPLETED	2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the fime, date end place, and due to the cause(s) and manner as stated.										
ш	296. SIGNATURE AND TITLE OF CERTIFIER	Tan	10	1		29c. LIC	ENSE NUM	BER			forth, Day Year)
TO B	-	1000		1)		D-	2337	1	1 > 1	JOV3,	195
F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITE	W 27) (Туре,	Print)					= (
	Dr. Qamar Zaman-	-Johnson	Heights	Med	ical B	uildin	g-C111	mberland	MD	21502	
	31. DATE FILED (Month, Day, Year)	32. DEGISTRAL	R'S SIGNATURE .				- Jul	er rand	141		
	NOV 03 1995	Jalia d	aviden Ra	rdall							



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examiner must be notified at once.	be fled within 72 hours after death with the State Bept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
r death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TA hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	t. Vat	or S	18,		2. DATE OF DEATH	AY	year 3. TIME	OF DEATH
	4. SOCIAL SECURITY NUMBER 215-36-5217			UNDER I YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) August 6,		BIRTNPLACE (S	State or Foreign
TOR L	94. FACILITY NAME (If not institution, give s Washington Advent			akoma	Park		9c. COUNT	y of DEATH gomery	
DIRECTOR	10a. STATE 10b. COUNT	y ce George's		own or local	11129			LIM	BIDE CITY HTS?
FUNERAL	100. STREET AND NUMBER 6001 36th Avenue				. ZIP CODE		U.S.	N OF WHAT COL	
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 M YES 2 NO IF YES, GIVE WAR OR DATES WID T			If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: Specify:				Black, Whits,	etc.
COMPLETED		15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUA (Give kind of work of			lone during most of working ad.)				
_	17. FATHER'S NAME (First, Middle, Last) John Yator	2	Computer	Specia	18. MOTNER'S NAME (First, Middle, Maiden Surname)				
TO BE	196. INFORMANT'S NAME (Type/Print) Jeannette Yator		1			Wade Route Number, City or Tow ttsville, 1	-	•	782
	20a. METHOD OF DISPOSITION 1	Me	PLACE AND DATE OF DI netery, cremetory or other r ETTOPOLITAT	SPOSITION /No	me of	DATE 200 10	CATION CI	ne Town Ctate	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		Franci	s Gasch	s Sons Fur Ave.,Hyat	eral H	Home, P	.A.
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due To (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death Congression of the consequence of the consequ							oproximate terval Between	
CEMILIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d								
AL	PERFORMED? 1 YES DENO OF						AMAILABE COMPLET OF DEAT	UTOPSY FINDINGS LE PRIOR TO TION OF CAUSE H?	
HYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
-	1 VES 2 NO 27. MANNER OF DEATH 1 Vetural 5 Pending	HOSPITAL: Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Name 5 Raeldenca 6 Other (Specify)							
EIEU B	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY — All home, farm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or R City or Town, State)					Rural Route Num	ber,	
COMPLE	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and placa, and due to the cause(s) and manner as stated. Description of the cause(s) and manner as stated. Description one of the cause(s) and manner as stated.								
O BE	296. SIGNATURE AND TITLE OF CERTIFIER Lock M. Lock M. 296. LICENSE NUMBER 296. DATE SIGNED (Mor								
		o completed cause of DE	ATH (ITEM 27) (Type, Print	7680	Cari	roll Au	Par	IK N	som 2
NOV 02 1995 Some of the distribution hardely									



		Pages 1, 2, 3 should	
DALLIMONE, MANILAND 21213-0020	sed by the hospital or attending physician.	ould be detached for use as the burishtransit permit.	led at once.
IMONE, MA	t. Page 6 may be retail	nal director, page 5 sho	siner must be notif
DAC	hours after death	ed in by the fune , or removal.	medical exam
OF VITAL RECORDS, F.O. BOX 567 50	PerSIDAN. The law requires that the death certificate by executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	s certifician has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burishtransh permit. Pages 1, 2, 3 sho in the State Dept. or health and Mental Hygene prior to burish, crientation, or heronel.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION	THE HOSPITAL OR ATTENDING PHY	THE FUNERAL DIRECTOR: After this filed within 72 hours after thanh will	MPORTANT: If them 28 is marke

1 - FOR STATE REGISTRAR	STATE OF MARYL		T OF HEALTH AND	MENTAL HYGIEN REG. NO					
HELEN MILL					2. DATE OF DEATH DAY NOVEMBER 19 95 08:45 Am				
4. SOCIAL SECURITY NUMBER 216-14-7195 Bit FACILITY NAME (If not institute)	1 🗆 44 27 🗸 F	91 YRS. MONTH	ER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. TY, TOWN OR LOCATION OF D			BIRTHPLACE (State or Foreign Country) Maryland			
	00 Caton Aven		Baltimore		N/	****			
	N/A	10c. CITY, TOWN	or Location timore			10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
IGO, STREET AND NUMBER	10s. STREET AND NUMBER		101, ZIP CODE			OF WHAT COUNTRY?			
577 Beechfie		N I/ C ARMED	21229	NIC OBIOINS (Secolts Ve		ed States RACE - American Indian,			
11. MARITAL STATUS 1 Never Married 2 Married 2 XWidowed 4 Dispreed		2 (X)NO				Black, White, etc. Specify: White			
	T'S EDUCATION Int' grade completis() College (1-4 or 5 +)	16e. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retired	e during most of working	16b, KIND OF BU	SINESS/INDUST	RY			
- 8	2.00	homemak		own home					
17. FATHER'S NAME (First, MICKIN, I	AND				E (First, Middle, Malden Surname)				
UNKNOWN 198. REFORMANT'S NAME (Type/Fr	int)	19b. MAILING ADDRI	unkno		rn, State, Zip Coo	je)			
Charlotte Fo	enves	1204 Se	ven Oaks Ro	oad Arbut	us, Ma	rv1and21227			
20s. METHOD OF DISPOSITION DC Burtar 2 Committee 3 4 Donation 5 D Other (Speci	☐ Removel from State Cer.	b. PLACE AND DATE OF DISP	OSITION (Name of	DATE 20c. LO	CATION — City				
21. BIGNATURE OF FUNERAL BER			2. NAME AND ADDRESS OF FA	ACILITY					
100	of the		ambrose rui 1328 Sulphi		-	21227			
	disease or condition to the property of the state of the								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST LACUTE LENGL Joilles 1/4/2014 LAST LACUTE LENGL Joilles 1/4/2014 LONGE Tive LONG Toilles 1/4/2014 LONGE Tive LONGE Tive LONGE DUE TO (OR AS A CONSEQUENCE OF):									
PERFORMED? 1 Tyes 2 MO						24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO			
DID TOBACCO USE (CONTRIBUTE TO CAUSE O	OF DEATH YES	NO UNCERTA	IN 🗆					
EXAMINER?									
1 TYES 2 YNO	1 Inpetient 2 ER/Out	patient 3 🗆 DOA 4 🗀	iursing Home 5 Reeldence	6 Other (Specify) 28d. DESCRIBE HOW	IN ILIEN OCCUR	en			
1 Natural 5 Period	(Month, Day, Year)	Y — At home, farm, street,	WORK? 1 YES 2 NO						
3 Suicide 8 Could 4 Homicide deter	281, LOCATION (Street City or Town, State	et end Number or Rural Route Number, ite)							
(Check day	Check only Check on Check only Check on Check only Check on C								
29b. SIGNATURE AND TUTLE OF C		29c. LICENSE NU D - 457			IGNED (Month, Day, Year) OVEMBER 18'S.				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) H. RACHOCKA SOCCATON AND BAUTO, MP 21228									
NOV 2 0 1995	AT .	ATURE							

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle (ast) 3. TIME OF DEATH SARAH D. AHNELL 11:55 P M Nov. 15, 1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 KF 83 261-50-3373 Apr. 26, 1912 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Long Green Baltimore N/A 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. Baltimore Cockeysville 1 TYES 2 TONO 10e. STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12-1B Warren Lodge Ct. 21030 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 4HO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried 1 YES 2 NO Specify Specify: BY 3 Widowed 4 Divorced White ETED | 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi (Give kind of work done life. Do NOT use retired.) st of working Elementary/Secondery (0-12) College (1-4 or 5+) COMPL Owner Nursery School once. 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Ħ Feehan John Smith Catherine notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 4519 Hydes Rd. Hydes, Md. 21082 Joseph E. Ahnell pe 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of 2 In the second must Hilltop Service Corp. Towson, Md. examiner 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 21, SIGNATURE OF FUNERAL SERVICE LICENSEE +ggo-1050 York Rd. Towson, Md. 21204 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List pniv one cause on each line. Approximets Interval Between IMMEDIATE CAUSE (Finel Onset and Death Myocardial Infaction disesse or condition resulting in death) traumatic event, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24h. WERF AUTOPSY FINDINGS PERFORMED? AMAIL ARL E PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO. OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN W PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item **EXAMINER?** OTHER:
4 A Moraling Home 5 Residence 8 Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 20 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 284 DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Netural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) DIRECTOR: Affinous after de item 28 is r 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER

(Check ank.)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data end place, end due to the cause(e) and manner ee stated. FUNERAL (within 72 h TANT: If it 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) and menner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Fig. 16or) BE (48) D53887 30. MAKE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Vissing, M.D. 4300 N. Charles St. Baltimore, Md. 21218 32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year) NOV 2 0 1995

DIVISION OF VITAL RECORDS, P.O. BOX 6876

	Pages 1, 2, 3 should		
JAN: THE IAM REQUIRES THAT THE DEATH CENTRALE DE EXECUTION WITHIN 24 HOURS AFRET DEATH. FAUR OF THAT DE FEMILEO DY THE HOSPITAL OF ALTERNATION.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sh		
me nosbirai	detached for		iffed at once.
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je o may ne	irector, page		ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
Dealli. ra	e funeral di	, i	examiner
HOURS AIRE	led in by th	, or remova	medicai
47 HILLIA D	ompletely fil	I, cremation	event, the
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w requires t	been signer	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	3 shows a
JAN: 1 Ne 18	rtificate has	he State Der	or item 2;
ING PHYSIC	After this ce		is marked,
UH ALLENT	DIRECTOR: ,	filed within 72 hours after death with	
HOSPITAL	FUNERAL	within 72	RTANT: If item 28
PA C	ž	e filed	APO

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
ast)		2. DATE OF DEATH

	FOR 1 - STATE REGISTRAR	STATE OF MAR		/ DEPAR					MENTAL	HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	DEATH			3. TIME OF OE	ATH
1	William L. Basi	l, III							NOV.	18,		YEAR 195	1:56	Ам
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. I	ast birthday)	IF UNDER	1 YEAR	IF UNDER 2	4 HRS.	7. DATE OF	BIRTH Day, Year)		8. BIRTH	PLACE (State or	Foreign
	220-05-9110	1 X M 2 F	75	YRS.	MONTHS	DAYS	HOURS	MATPA,	SEP.	3, 19	20		yland	
~	9a. FACILITY NAME (If not institution, give s				9b. CITY	, TOWN C	R LOCATION	N OF DE	ATH		9c. COUNT	TY OF O	EATH	
DIRECTOR	6045 Florey Road	<u>t</u>			Har	ovei					Нс	war	d	
EC	10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN (OR LOCAT	ION			-			10d. INSIDE CIT	ΓY
5	Md. Hov	ward		На	nove	r							LIMITS?] NO
AL	10e. STREET AND NUMBER					101	ZIP CODE				10g. CITIZ	EN OF V	VHAT COUNTRY?	
FUNERAL	6045 Florey Road	t					2107	76			L	ISA		
1	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1	YES 2 X	ARMED NO					IIC ORIGIN?		or No-	14. RACE Black	E — American inc k, White, alc.	dian,
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES			1 YES	5 X NO	Specify	r:			Speci	white	
	15. DECEDENT'S EOU	CATION		DECEDENT'S					16b. F	IND OF BUS	INESS/INDU	STRY	WIITE	
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	- 1	(Give kind of ite. Do NOT u	work done se retired.)	during mo	st of working	,						
AP	8	N/A		illwr	ight				E	ig Bo	y Rig	gin		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)								ME (First, Mid		Surname)			
BE	William L. Basi	ll, Jr.							Kelly			111		
2	190. INFORMANT'S NAME (Type/Print) Gladys R. Basil		1						Route Numbe					
1		4	00h BI 00	CAND DATE				Han	over,		CATION — C		00.4	
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremption 3 Ram 4 Donation 5 Other (Specify)	ovel from State	cemetery, c	crematory or c	ther place)	unt	Cemet	orv	, 11/2	1 Ra	1+imo	ITY OF 10	Md	
	21. SIGNATURE OF VALUE LA	ENSEE	1110	, or oc			ID ADDRESS			<u> </u>	TOTING	16,	nu.	
	→ ZL////////////////////////////////////		_										Elk., I	nc.
	23. PART I. Enter the diseases or	complications that ca	used the	death Do	<u>156</u>	95 M	lain S	St.	Elkr	idge.	Md.	21	227 Approxi	mete
	shock, or haart dilum.	List only one cause	on each Ili	ne.			do or dym	g, adoi		io or reapi	ratory arre	ant,	interval	Batween nd Daath
	iMMEDIATE CAUSE (Final disease or condition	M	والرياء	Trade		Dro		4-1	W 04					CALA
	resulting in death)	a. OUE TO (OR	AS A CONS	SEQUENCE O	F):	1)/(7 (4)	100	-11/00				,	016
Z	Sequentially list conditions.													
Ĕ	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
일	CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	that Initiated evanta DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
2		0.												
¥	PART II. Other algorificant condition	ontributing to da	nth but no	t rasulting	In tha u	nderlyin	g causa gl	Ivan In	Part i.	PERFOR		24b	WERE AUTOPSY WAILABLE PRIO	OT R
ă	Seizures zu	ואמוכויי צ	A TU	www.	CV	A 2	W 111	CE OU	_	T YES 2	NO		OF DEATH?	
Σ	DID TOBACCO USE CONT	DIDLITE TO CALL	E OE DE	ATLI V	EC	NO E	Y LINICI	EDTAIN	N. [1 YES 2 1	NO
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SIC	EXAMINER?	HOSPITAL:	l/Outpatient	3 DOA	OTHE 4 Nu	R:	5 D Kan	idence	8 Other	(Specify)				
Ή	27, MANNER OF DEATH	28a. DATE OF INJ (Month, Day,	URY	28b. TIR		28c. IN.					NJURY OCC	URED		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(months, Day,	our/		M		YES 2	NO						
	3 Suicide 6 Could not be	26a. PLACE OF IN building, etc.	JURY — A1 (Specify)	home, farm,	atreet, fac	tory, offic	8			TON (Street a Town, State)	and Number	or Rural i	Route Number,	
E	4 Homicide determined							111 = 1						
COMPLETED	contain only	SICIAN: To the beat of my												
S S	2 MEDICAL EXAMINI	ER: On the basis of axem	Ination and/o	or investigati	on, in my	opinion, c	leath occure	d at the	time, data a	nd placa, an	d due to the	cause(a) and manner as	stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIE	ROLL	<u> </u>	41.1	1		29c. LICEI						(Month, Day, Yea	er)
10	30. NAME AND ADDRESS OF PERSON WE	ex from	<u>xuu</u>	W	N)		D	00	328	8	1	1/3	10/62	
	Melvinj Kori			OID	-	0.	HAI	\ 0	D	511	n the	1	mb 2	INI
اند	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S			יביט	7	11241	1	01.	LIIC	ONC	eny	mo	142
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ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Neuins W 31. DATE FILED (Month, Day, Year) NOV 2 0 1995

Jr. M. L 32. REGISTRAR'S SIGNATURE Divolentable

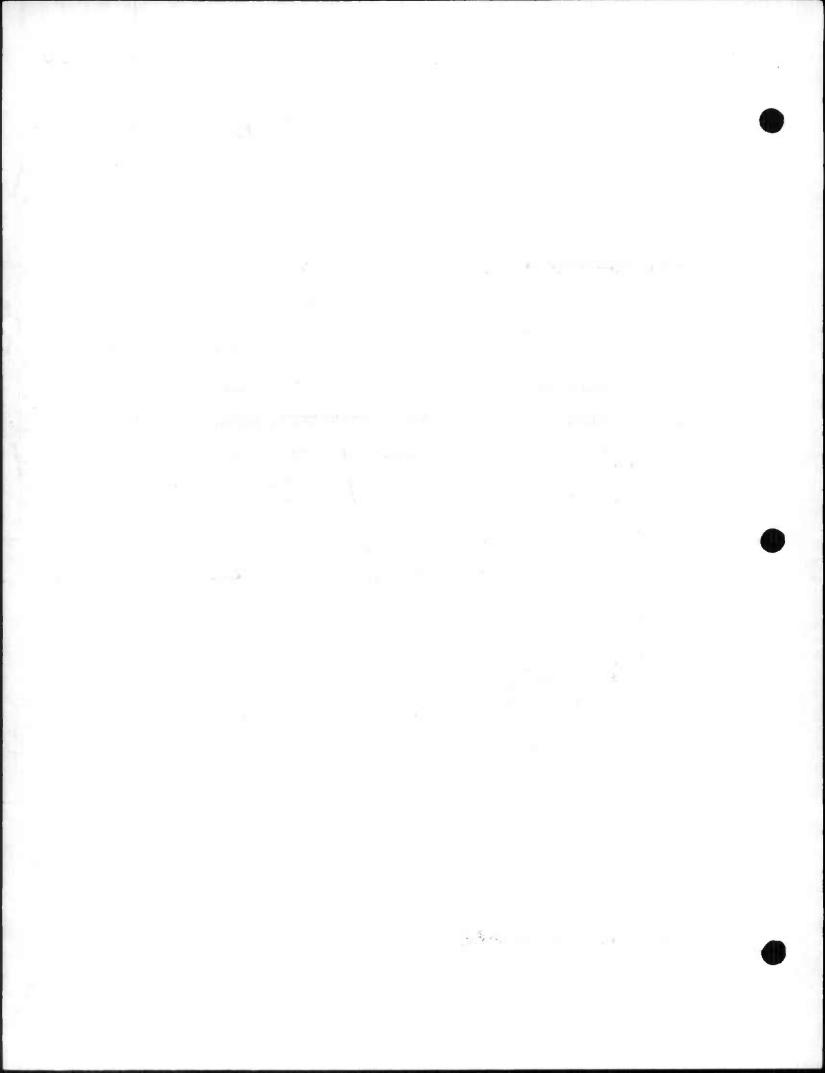
be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Item21 11-27	-95 FilmG/	Z) Wells	TOT I'	£1.				40	5	34898
	1 - STATE REGISTRAR	STATE OF	F MARYLAN		TMENT OF I		D MENT		_		
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	LOREN		DECE	ED		1 6	MON		-	YEAR	3. TIME OF DEATH
		W.	BECK			u,		ovember	191	1995	1030 A M
	4. SOCIAL SECURITY NUMBER 009-10-5708	5. SEX	F 72	rs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN	06.	-20-192	3	Counti	HPLACE (State or Foreign ny) MONT
	9a. FACILITY NAME (If not institution,				9b. CITY, TOWN	OR LOCATION OF	F DEATN		9c. COU	INTY OF D	DEATN
DIRECTOR	PENINSULA F	NT	EDICAL			SALIS	BURY			WICC	OMICO
	DELAWARE KEN	NT		DOV	y, town or loca ER	TION					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 205 MACARTHUR I	OPTVFP			1.00	1. ZIP CODE			10g. CIT		WHAT COUNTRY?
N	11. MARITAL STATUS		DENT EVER IN U.S								
В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	XX YES 2	□ NO	If yes, sp	CENDENT OF HIS secify Cuban, Mei 2 X NO Sp	xican, Puert	ilN? (Specify Yes o Rican, atc.)	or No—	Speci	E — American Indian, k, White, etc. #y: HITE
	15. DECEDENT' (Specify only highest	'S EDUCATION	16:		USUAL OCCUPATION		11	6b. KIND OF BUS	SINESS/INC	DUSTRY	
ш	Elementary/Secondary (0-12)	College (1-4 or	(5+)	life. Do NOT us	vork done during mo e retired.)	ost of working					
릴	12	00		WNER/O	PERATOR			CENTER	CITY	DEL	ICATESSENE
COMPLETED	17. FATHER'S NAME (First, Middle, La	ast)				16. MOTNER'S	NAME (First	, Middle, Malden	Sumama)		
O	WALTER EDWARI	D BECKER						LA HASW	- /		
BE	19a. INFORMANT'S NAME (Type/Print			105 MAIL INC	ADDRESS (Street a					0.41	
2	GERTRUDE BECKE				ACARTHUR						
	20a. METHOD OF DISPOSITION		201.01	1.							
	Buriel 2 Cremetion 3 Donation 5 Other (Specify	r)	cemeter DEL	y, crematory or of MEMOR	of disposition (Net)	CEM.	1		BEA		even, State ELAWARE
	21. SIGNATURE OF FUNERAL SERVI	ICE LICENSEE	-		22. NAME A	ND ADDRESS OF	FACILITY				
	Thomas R.	Trader				R FUNER				01	
- 1					IZ LU	TUS ST.	. DOV	ER, DE.	199	UL	
	23. PART I. Enter the diseases	s, or complications	that caused the	e deeth. Do n	ot enter the mo	OTUS ST.	DOV	ER, DE.	ratory an	rest,	Approximata
	anock, or neart tal	s, or complications i	that caused the	e deeth. Do n	ot enter the mo	OTUS ST.	uch as ce	ER, DE.	199 ratory an	rest,	interval Between
Į,	IMMEDIATE CAUSE (Finel disease or condition	s, or complications	that caused the	e deeth. Do n	not enter the mo	TUS ST.	DOV	ER, DE.	199	UI.	
	IMMEDIATE CAUSE (Finel	a.	that caused the cause on each	line.	Lelus	OTUS ST.	DOV	ER, DE.	199	UI	interval Between
z	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a.	nyo cus	line.	Lelus	orus st.	such as ce	rdiec or reeple	199	rest,	interval Between Onset and Death
NOI	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions,	a. Due	nyo cus	Ine.	sole enter the mo	ode of dying, a	such as ce	ER, DE.	199	rest,	interval Between
CATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. Due	Typeses Typeses Typeses Typeses Typeses Typeses Typeses	Ine.	sole enter the mo	orus st.	such as ce	rdiec or reeple	199	rest,	interval Between Onset and Death
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25 medical Center

Salishury, Md



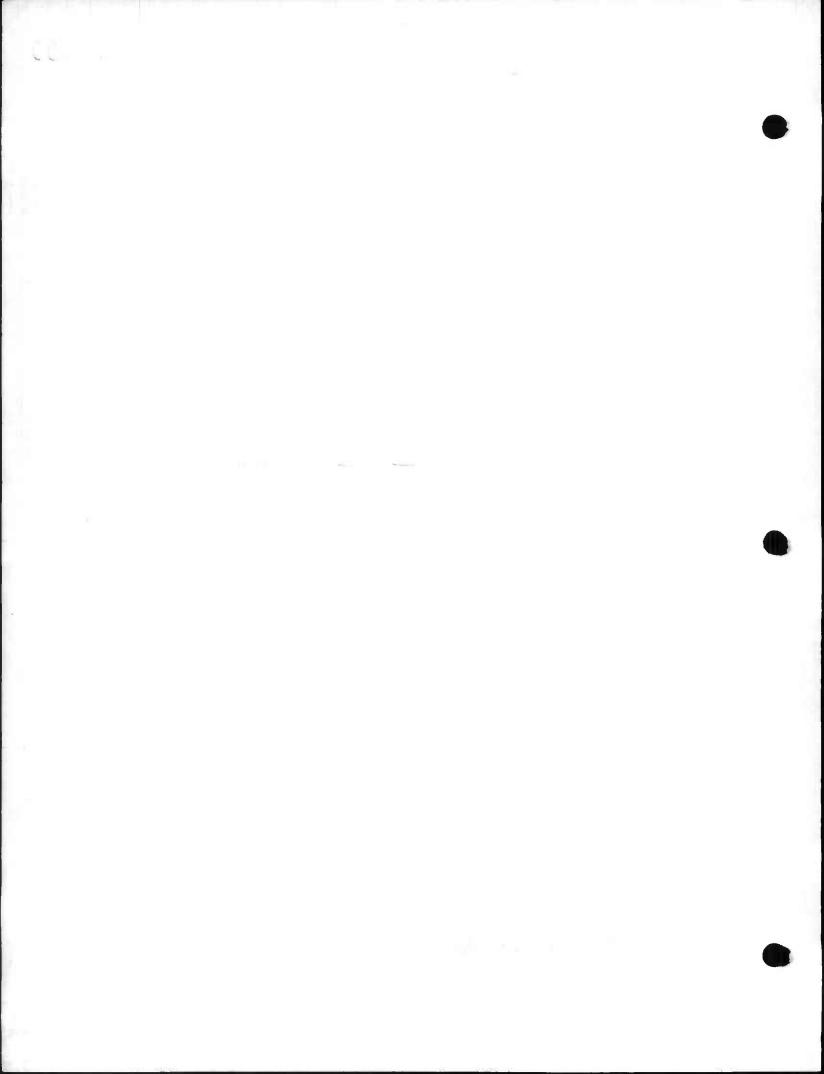
ICIAN: The law requires that the serificate has been signed by the State Dept. of Health and I, or Item 23 shows any In.	HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA nours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	id, or item 23 shows any injury, or other traumatic event, the medical axaminer must be notified at once.
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

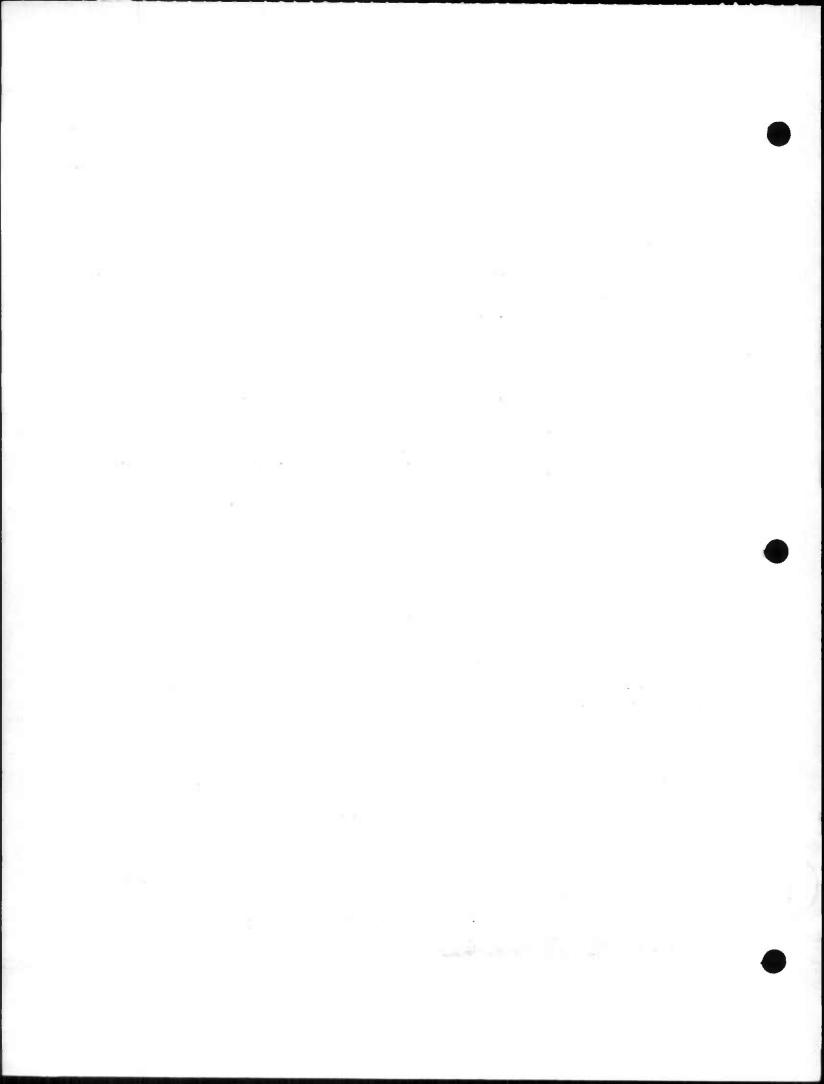
	REGISTRAR				ATE OF	DEATH	REG. NO.		
4 15	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. TIME OF DEATH
	Marie There	sa Blar					MONTH DAY		01150 "
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last bi		UNDER 1 YEAR	IF UNDER 24 HRS.	11 - 06 ·		0112
		1 M 2 2 F		MO	NTHS DAYS	HOURS MIN.	(Month, Day, Year)	Cour	THPLACE (State or Foreign otry)
- 9	212-18-8270		72	YRS.		1.0140	04-14-23	Ma	rvland
1	Se. FACILITY NAME (If not institution, give	street and number)		9b	96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH				
E I	1717 N. Fulton		D-						
DIRECTOR	1717 N. Fulton Ave. Baltimore None								
iii	10s. STATE 10b. COUNT	Υ	1	Oc. CITY, TO	OWN OR LOCA	TION			10d. INSIDE CITY
	Maryland No.	ne			т	22145			LIMITS?
	10e. STREET AND NUMBER				10	Baltimor LZIP CODE	е	10a CITIZEN OF	WHAT COUNTRY?
FUNERAL	1717 2 2 2				1.00	. Lir Cobe		rog. Citizen Or	WHAI COUNTRY?
빌	1717 N. Fulton	Ave.				21217		USA	
5	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1		D	13. WAS DEC	CENDENT OF HISPAN	IC ORIGIN? (Specify Yes on, Puerto Rican, etc.)	or No — 14. RAC	CE — American Indian, ck, White, etc.
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR				2 NO Specify			offy:
	3 WHOWARD 4 DIVORCED								Black
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🔄	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do	NOT use re	tired.)	ist or working			
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ਨੂੰ	17. FATHER'S NAME (First, Middle, Last)		Icust	Outa	ii rec		Seton ME (First, Middle, Maiden S		ite
		. 1							
B	James P. Bui	nay				Mary D	ella Stev	vart	
2	19a. INFORMANT'S NAME (Type/Print)		196. M	IAILING AD	ORESS (Street	and Number or Rural F	loute Number, City or Town,	State, Zip Code)	
	Theresa L. Whit	ie	117	17 N	I. Full	ton Ave	Balto	MA	21217
	20a. METHOD OF DISPOSITION		20b. PLACE AND	DATEOFD	ISPOSITION (N	ame of	Balto DATE 20c LOC	ATION — City or 1	Town, State
	1 X Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	ioval from State	cemetery.	KING	MEM. PA	RK 1	DATE 20c. LOCA 1/11/95 Rand		,
1	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1	-110	DO NAME A	ND ADDRESS OF FA	Ranc	allsto	own, Md
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	made	CO	Vina.		4611	Dowle II	Jones Fur	ieral F	iome
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ter death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should wal.	al examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
IN THE MOSTITUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FLIVETOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	TE OF MARYLAND / I	DEPARTMENT OF H		ENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	MILLARD T. BA	RRY, JR.			MONTH DAY	18 95	
	4. SOCIAL SECURITY NUMBER 5. SEX	, , , , , , , , , , , , , , , , , , , ,	MONTHS DAYS	IF UNDER 24 HRS.	7, DATE OF BIRTH (Month, Day, Year)	6. BIRT	HPLACE (State or Foreign try)
	216 09 100 18 1	M 2 F 77	YRS.	R LOCATION OF DEAT	5/26/18	9c, COUNTY OF	Md.
OB		EDILAL CENTE		ORE, MI	- 1	BACTIME	
DIRECTOR	RESIDENCE OF DECEDENT		10c, CITY, TOWN OR LOCAL				Low control of the co
2	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCAL	ION			tod. INSIDE CITY LIMITS?
	Md. N/	A	Baltimor			_	1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER		101	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
E	3322 Strickland S	StBaltimo	re, Md.	21229		U.S	.A.
5	F0	AS DECEDENT EVER IN U.S. ARM DRCES? 1 DE YES 2 NO		ENDENT OF HISPANIC	ORIGIN? (Specify Yes	or No — 14. RAG	CE — American Indian, ck, White, stc.
	1 Never Married 2 150 Married	YES, GIVE WAR OR DATES		NO Specify:	Puerto Hican, etc.)	Spe	
ВУ	3 Widowed 4 Divorced	W.W. II					White
COMPLETED	ts. DECEDENT'S EDUCATION (Specify only highest grade complete	16a. DEC	EDENT'S USUAL OCCUPATION Re kind of work done during me	ON st of working	16b, KIND OF BUS	INESS/INDUSTRY	
ᄪ		ife. (Do NOT use retired.)				
P	Grade 8	Tru	ck Driver		Bowma	n Truc	k Co.
ő	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME	E (First, Middle, Malden S	Surname)	
E	Millard Barry	Sr.		Mary 1	E. Kirby		
8	19a. INFORMANT'S NAME (Type/Print)		. MAILING AOORESS (Street				
2	Catherine C. B	0 22227	322 Strick	land St	-Balto	ьм	21220
	20a, METHOD OF DISPOSITION	20b PLACE AT	ND DATE OF DISPOSITION IN			ATION — City or	
	110 Buriel 2 Cremation 3 Removal fro	om State cemetery, crem	netory or other piece)				and the same of th
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		National	D ADDRESS OF FACI		Darto.	Ma
	Motion				ick Aver	ue	
	G. Truman Sc	hwab			Md. 2122		
	23. PART i. Enter the diseases, or compile		oth. Do not enter the mo				Approximate
	ehock, or heart failure. List on IMMEDIATE CAUSE (Final	ily one cause on eech line.					Interval Between Onset and Death
	disease or condition	SEPSIS					
	reaulting in death) a	DUE TO (OR AS A CONSEC	UENCE OF):				
_	1	ASPIRATION	PARLIMAN	. 12			
CERTIFICATION	Sequentially flat conditions,	OUE TO (OR AS A CONSEG		117			
AT	if any, leading to immediate cause. Enter UNDERLYING	Mynemania	INGA	(177 ()			
FIC	CAUSE (Disease or Injury	MYOCARDIA DUE TO (OR AS A CONSEG	UENCE OF):	LILON			
E	that inflieted events resulting in death) LAST d. CEREBROURSCULAR ALCIDENT						
E	4	COLEDECOL	TOUR I	ILCI VENI			
AL	PART II. Other significant conditions cont	irlbuting to deeth but not re	euiting in the underlying	g ceuee given in P	art i. 24s. WAS AN		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
-	CHRONIC DESTRUC					- /	COMPLETION OF CAUSE
S		TIVE FULMS	MARY DE	EASE	1 YES 2	NO I	
EDICA		TIVE PULMO		EASE	1 TYES 2	No	OF DEATH?
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MEDIC		TE TO CAUSE OF DEAT	KEMIA	· ·		No	OF DEATH?
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

allen Reilly, md Residen

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typa, Print)

Dri Reilly A

FOR 1 - STATE	STATE OF MARYL		MENT OF HEALTH AND I		95 34901
REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CENTIFIC	AIE OF DEATH	REG. NO.	3. TIME OF DEATH
EDITH	31	IRD		NOV 9	1995 1220 M
4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	, ,	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year),	S. BIRTHPLACE (State or Foreign Country)
216-22-4585	1 - M 2 F	70 YRS. "	ONTHS DAYS HOURS MIN.	July 16, 192	5 Marylans
9a. FACILITY NAME (If not Institution, give	street end number)	9	b. CITY, TOWN OR LOCATION OF DE	EATH 9c.	COUNTY OF DEATH
St. Hques	Jospital		Baltinere		NIA
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCATION		10d. INSIDE CITY
Marylano	HA	R	saltimure		LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER		11	10f. ZIP CODE	10g	. CITIZEN OF WHAT COUNTRY?
1836 W. L	anuals '	STYEEL	3171	7	USA
11, MARITAL STATUS	12. WAS DECEDENT EVER I	IN U.S. ARMED	13. WAS DECENDENT OF HISPAN II yes, specify Cuban, Maxica	IIC ORIGIN? (Specify Yea or No. Puerto Rican, etc.)	o- 14. RACE American Indian, Black, White, alc.
1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TYES 2 NO Specify		Specify
15, DECEDENT'S EDI	JCATION	16a, DECEDENT'S US	SUAL OCCUPATION	16b, KIND OF BUSINES	S/INDUSTRY
(Specify only highest grad	completed) College (1-4 or 5 +)	(Give kind of wor	rk done during most of working retired.)		
124 GArs		HOUSE	wife	pan n	ume
17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Maiden Surna	ime)
Oswald B	10-0		Mar	TE ROBE	erts
19a. INFORMANT'S NAME (Type/Print)	1	19b, MAILING A	DDRESS (Street and Number or Rural)	Route Number, City or Town, Sta	te, Zio Code)
bevery ca	rter	14221	+ Harkston	strut pa	STIMULE MONGLAND
29a. METHOD OF DISPOSITION Burlal 2 Cremation 3 Ren	noval Irom Stata	b. PLACE AND DATE OF metery, crematory or other	er plage)	1 15/95 D	ON — City or Town, State
4 Donation 5 Other (Specify)	ICENSEE	TE WOR	22. NAME AND ADDRESS OF FA	CIUTY 5) 40 20	15 TENSTONE PRAY CONE
			11	. 17/1-	1310/310000 120/20
Dewy To	ulso		CHATNUM- HA		CHIMIE, IKA JIJIS
23. PART Enter the/diseeses, or shock, or heert fellure	complications that cause List only one cause on a		t enter the mode of dying, suc	h as cardiac or respirator	Interval Between
IMMEDIATE CAUSE (Finel	Pas	- 10 0.0	500 - Til	10- 70 AA	Onset and Death
disease or condition resulting in death)	· new	0112071	019 10110	ine 2° CC	IPP ZWRS
	DUE TO (OW AS	A CONSEQUENCE OF):	monary do	christive	Direct 15ucc
Sequentially liet conditions,	DUE TO (OR AS	A CONSEQUENCE OF):	morning ce	20.0-1.00	Discus 12913
if any, leeding to immediate cause. Enter UNDERLYING	Sec-	nures			
CAUSE (Disease or injury that initieted events	PUE TO (OR AS	CONSEQUENCE OF):	20 1	1 11/1	11 1 5
resulting in deeth) LAST	. Jeme	entra	2º Ce	rebral VASI	cular Ax. 5yrs
PART II. Other significent condition	ons contributing to death	but not resulting in	the underlying cause given in	Pert I. 24s, WAS AN AUTO	OPSY 24b. WERE AUTOPSY FINDINGS
				PERFORMEO	COMPLETION OF CAUSE
				1 TES 2	OF DEATH?
DID TOBACCO USE CON	TRIBUTE TO CAUSE (OF DEATH YES	□ NO □ UNCERTAI	ND	16.160 22.10
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH			
EXAMINER? 1 VES 2 NO	HOSPITAL:		OTHER: 4 - Nursing Home 5 - Realdenca	6 Other (Specify)	
27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)		OF 28c. INJURY AT	28d. DESCRIBE HOW INJUR	Y OCCURED
1 Netural 5 Pending 2 Accident Investigation			M 1 YES 2 NO		
3 Suicida s Could not be	28a. PLACE OF INJUR building, atc. (Sp	RY — At home, larm, streetly)	reet, lactory, office	281. LOCATION (Street and N City or Town, State)	lumber or Rural Route Number,
4 Homicide daterminad					
29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of my kno	wiedge, death occurred	d at the time, date and place, and due	to the cause(a) and manner	as stated.

29c. LICENSE NUMBER D 7629

29d. DATE SIGNED (Month, Day, Year)

NOV, 9,199

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BALTIMORE, MARYLAND 21215-00;	LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be may be retained by the bosonital or attending
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	9
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the horself-trainal permit. Page 6 may be falled within 72 hours after death with the State Depty of Health and Mental Hygiene prior to build, creation.

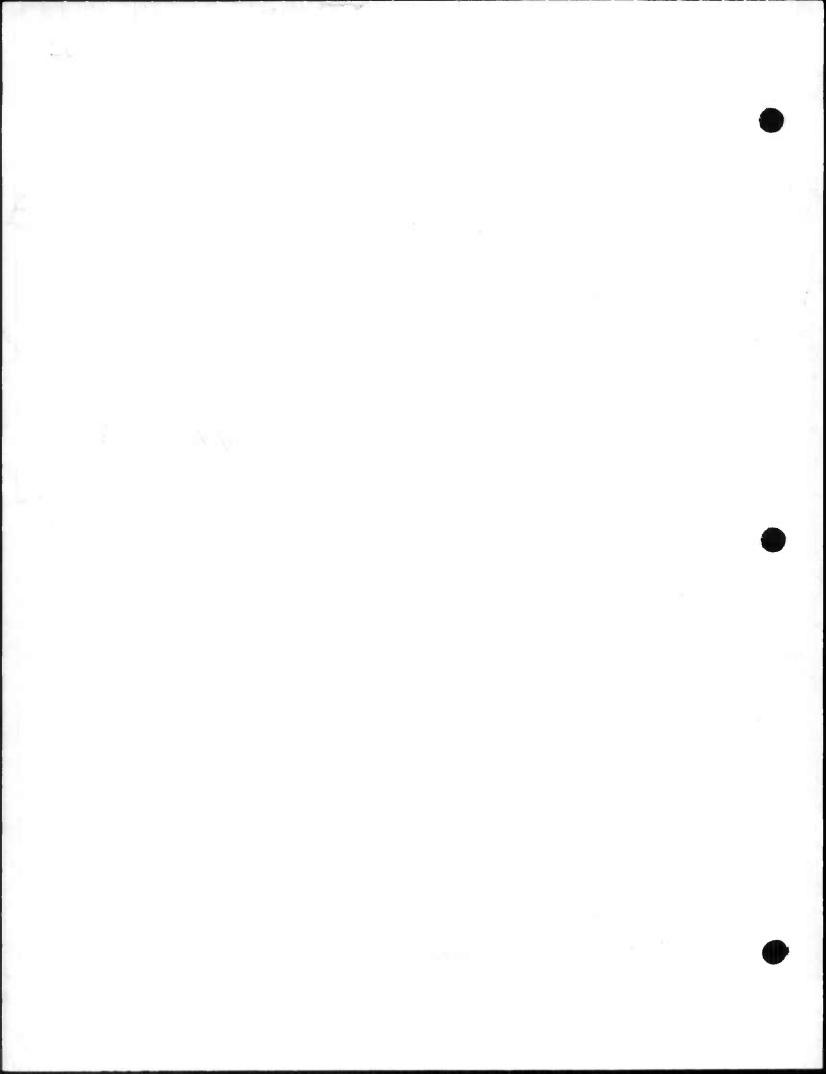
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Linst)

2. DATE OF DEATH
MONTH
DAY

	REGIOTRAN		CENTIFIC	ATE OF DEATH	REG. NO	0	
- 1	1. DECEDENT'S NAME (First, Middle, Linst)				2. DATE OF DEATH	DAM AFFIRM	3. TIME OF DEATH
	ELIZA AL	-UERTA	BRO	NW		DAY YEAR 3 1995	07.
	4. SOCIAL SECURITY NUMBER 5.		(In yrs. last birthday)	F UNDER 1 YEAR IF UNDER 24 HRS	1		THPLACE (State or Foreign
-	212-42-551.71	□ M 2 □ F		ONTHS DAYS HOURS MIN	(44	Con	untry)
1	210 10 001				Mar 2	1, (921 M	arylano
-	9e. FACILITY NAME (If not institution, give street	t and number)	11 / 1	b. CITY, TOWN OR LOCATION OF	DEATH	9c. COUNTY OF	DEATH '
DIRECTOR	UNIUERSILY OT	narylan	Hospital	Bultim	NE	1	12
5	RESIDENCE OF DECEDENT		1 1			1	
#	19e. STATE 10b. COUNTY	. 1	10c, CITY,	TOWN OR LOCATION			10d. INSIDE CITY LIMITS?
	Maryano N	A	- 1	Saltimore	,		1 TES 2 NO
4	100. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL	2507 KEGLINV	H. Dur	CA 1 (16.	2121		110	n.
13	11. MARITAL STATUS 12	2. WAS DECEDENT EVER II	HUS ARMED	13. WAS DECENDENT OF HIS	ANIC OBIGINS (Second, W	1 0 3	77
	1 Never Merried 2 Merried	FORCES? 1 YES	2 NO	If yes, specify Cuben, Mex	ican, Puerto Rican, atc.)	BI	ACE — American Indian, ack, White, etc.
B	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D.	ATES	1 TYES 2 NO Spo	elfy:	Sp	Nethy:
	15. DECEDENT'S EDUCATE	ON	16a. DECEDENT'S US	I COMPATION			PIACK
	(Specify only highest grade com	npleted)	(Give kind of wor	k done during most of working	16b. KIND OF BI	JSINESS/INDUSTRY	
1 5	Elementary/Secondery (0-12)	College (1-4 or 5+)	11	. /	0 6	600000	
링불	CAN GROAG		4002E	Wite	Our	home	
er once.	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	NAME (First, Middle, Maide	n Surname)	
LIJ 69	KUBERT JONES	7		Este	1E 1h0	mpson	
B B	19a, INFORMANT'S NAME (Type/Print)	2 11	19b. MAILING AL	ODRESS (Street and Number or Ru	al Route Number, City or To	wn, State, Zip Code)	212-07
2	Kathlesw Mal	ellough	68121	Fosting P	in Bolk	here Y	1
2	20a. METHOD OF DISPOSITION	20110001	PLACE AND DATE OF	2631111308	UNIC POUT	THOSE !	narylans
examiner must be notified TO BI	1 Buriet 2 Cremation 3 Removat		etery, crematory or other		1771795	CATION — City or	Town, State
E	4 Donation 5 Other (Specify)	St	· LUKE 'S	U.M. Chure	ncien. R	ELSTERS	town there
Ē	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22. NAME AND ADDRESS OF	FACILITY 5240	ecisters	HOWN ROAD
ž X	Allen de	4110		Mischen II	WINTE		10,13,13,100
	23. PART I. Enter the discessa, or com	collections that source	I the death Decem	Lieginan-N	BWILL I	MALL DULK	NKY 7-1712
	shock, or heart fallure. List	t only one cause on e	ech line.	enter the mode of dying, s	uch as cardled or resp	olratory arrest,	Approximata Interval Between
E	IMMEDIATE CAUSE (Finel			1 1			Onset and Death
	disease or condition a,	1ntR	ACERE	bral H	emorr	2010	13 hours
event,	u		CONSEQUENCE OF):		OI TOK!		101000
CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF):				
A	If any, leading to immediate cause. Enter UNDERLYING						i I
TIFIC	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):				
	resulting in deeth) LAST		,				i I
	d		<u> </u>				
	PART II. Other algnificent conditions co	ontributing to death b	ut not resulting in	the underlying cause given	In Part I. 24e, WAS A	ALITTOPEV 2	4b. WERE AUTOPSY FINDINGS
				,	PERFO	RMED?	AVAILABLE PRIOR TO
DIC	-				1 TYES	2 10 NO	COMPLETION OF CAUSE DF DEATH?
							1 TES 2 NO
PHYSICIAN: M	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES	□ NO 🖾 UNCERTA	JN 🗆		
BY PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH				
SIC		OSPITAL: ☐ Inpatient 2) ER/Outp		THER:	6 Other (Specific)		
. E	27. MANNER OF DEATH	280. DATE OF INJURY	28b. TIME C		28d. DESCRIBE HOW	INJURY OCCURED	
0	1 Natural 5 Pending	(Month, Day, Year)	INJUR	WORK? M 1 YES 2 NO		mon occones	
B \	2 Accident Investigation	26 - DI ACE OF IN HIPW	A. L				
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	— At nome, term, stre	et, factory, office	28f. LOCATION (Street City or Town, State	end Number or Rurs)	I Route Number,
2 0			101				
S E						Droc on stated	
S E		N: To the best of my knowl	edge, death occurred a	it the time, date and place, and d	ue to the causala) and ma		
S E	290. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN						ala) and mapped as stated
S E	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On			it the time, date end place, and d in my opinion, death occured at t			e(e) end manner ee stated.
S E	290. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN				he time, date end place, e	nd due to the cause	e(e) end manner ee stated. ED (Month, Day, Year)
BE COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O. 29th. SIGNATURE AND TIVLE OF CENTIFIER	On the basis of exemination	and/or investigation, i	29c. LICENSE N	he time, date end place, e	29d. DATE SIGN	ED (Month, Day, Year)
COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On	On the basis of exemination	and/or Investigation, in and/or Investigation, in and/or Investigation, in and in an and in an analysis of the	29c. LICENSE N	ne time, date end place, e UMBER	29d. DATE SIGN	ED (Month, Day, Year) 1 13 1995
BE COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O. 29th. SIGNATURE AND TIVLE OF CENTIFIER	On the basic of exemination	and/or Investigation, in and/or Investigation, in and/or Investigation, in and in an and in an analysis of the	29c. LICENSE N	ne time, date end place, e UMBER	29d. DATE SIGN	ED (Month, Day, Year) 1 13 1995
BE COMPLETE	290. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O. 20th. SIGNATURE AND TITLE OF CENTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO. DAY ID HART 31. DATE FILED (Month, Day, Year)	On the basis of exemination	n and/or investigation, in and/or investigation, in and in an and in an an an an an an an an an an an an an	29c. LICENSE N	ne time, date end place, e UMBER	29d. DATE SIGN	ED (Month, Day, Year) 1 13 1995
BE COMPLETE	299. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: One) 2015. SIGNATURE AND TITLE OF CENTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	On the basic of exemination OMPLETED CAUSE OF DEA	ATURE	29c. LICENSE N	ne time, date end place, e UMBER	29d. DATE SIGN	ED (Month, Day, Year) 1 13 1995



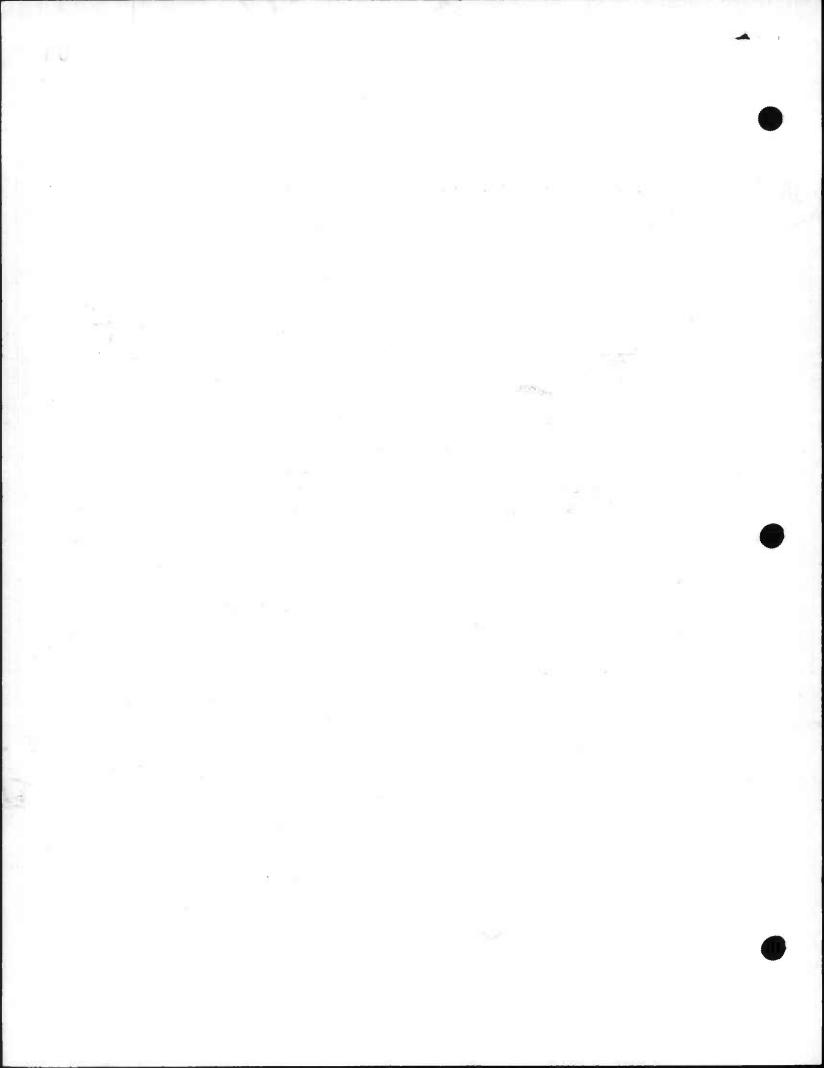
DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	IMPORTANT If hem 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	THE	THE De filed	MPDE

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN		
	DECEDENT'S NAME (First, Middle, Last) ANNA	LEE	BARC			2. DATE OF OEATH		3. TIME OF OEATN 2:50 RITI M
	4. SOCIAL SECURITY NUMBER 220-16-9220	1 □ M 2 ½ F 7	W 1990	MONTHS DAYS HOURS MIN. (Month				BIRTHPLACE (State or Foreign Country) Aryland
TOR	9e. FACILITY NAME (If not institution, give s Saint Joseph Medi				R LOCATION OF DI		9c. COUNTY Balt	OF CEATH DITTORE
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland 100. STREET AND NUMBER	Baltimore		Loi	ZIP CODE	Dundalk		1 YES 2 NO
RA	2503 West Woodw	ell Road		101.		222		ed States
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 V Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO	2 XNO	If yes, spe	ENDENT OF NISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		RACE — American Indian, Black, Whita, alc. Specify: White
요	15. DECEDENT'S EDU (Specify only highest grade	I CATION	16a, DECEDENT'S U	SUAL OCCUPATION done during mos		186. KIND OF BU	(ISINESS/INDUST	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	st or working	Own	. Home	
COMPL	8 Years 17. FATNER'S NAME (First, Middle, Last)		Housew	coe	18. MOTHER'S NA	ME (First, Middle, Maider		
б ш	William James Ku	mbles				Catherine		
TO B	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox		
	Gerry Campbell		_			oppa, Mari		21085
200	20a, METHOD OF CISPOSITION X.X. Burial 2 Cremation 3 Rem 4 Donetion 5 Cigner (Amony)	noval from State	PLACEAND DATE OF PROPERTY OF OUR COMMENTS OF THE PROPERTY OF T	pisposition (Na er place) emetery	me of 11/18/	1995 E	Baltimo.	re. MD
CASIMINE	21. BIGNATUJE COLOGNETIAL SETTICE JA	Lash	1	Duda	RUCK FU	e. Dundal	of Du	ndalk, Inc.
	23. PART I. Enter the diseases, or complications that cause the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only pna cause the each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due To (or As A consequence of):							
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	с.	CONSEQUENCE DF)					
		d						
MEDICAL	SEPTIC SHOCK	ns contributing to death b	out not resulting in	the undarlying	g ceuee given in	Part I. 24s. WAS AI PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PNO
	DID TOBACCO USE CONT	RIBUTE TO CAUSE O			UNCERTAI	N 🗆		
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:		A [] 015 40 41		
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	DF 28c. INJ		6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED
BY F	1 Naturel 5 Pending 2 Accident Investigation			M 1 🗆 1	ES 2 NO			
	2 Secretary 3 Suicide 8 Could not be detarmined 28e. PLACE DF INJURY — At home, ferm, straet, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)							Rurai Route Number,
COMPLET	(Orlock Only)	SICIAN: To the best of my know ER: On the besie of examination						euse(e) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	ahh	Oho		29c. LICENSE NU D 3026	_		IGNED (Month, Day, Year)
인	30. NAME AND ADDRESS OF PERSON WE					-	1	
	NOV 2 0 1995	32 REGISTRAR'S SIGN	IATURE	,				

IN The law requires that the death certificate be executed within 2.	THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FINERAL DIRECTIONS: After this certificate has been stoned by the afterding physician and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the fineral direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in by the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and completely filled in the direction and c)
be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to benight common, or remost. The filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or remost. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	within 27 hours after death with 18 State Days of the State Days and Mental Hydrens prior to burial, cremation, or remost. **TANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	Mill. 1965 1, 4, 2 51000

FOR 1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Lest) Alice	Bond	2. DATE OF DEATH DAY NOVEMBER 1

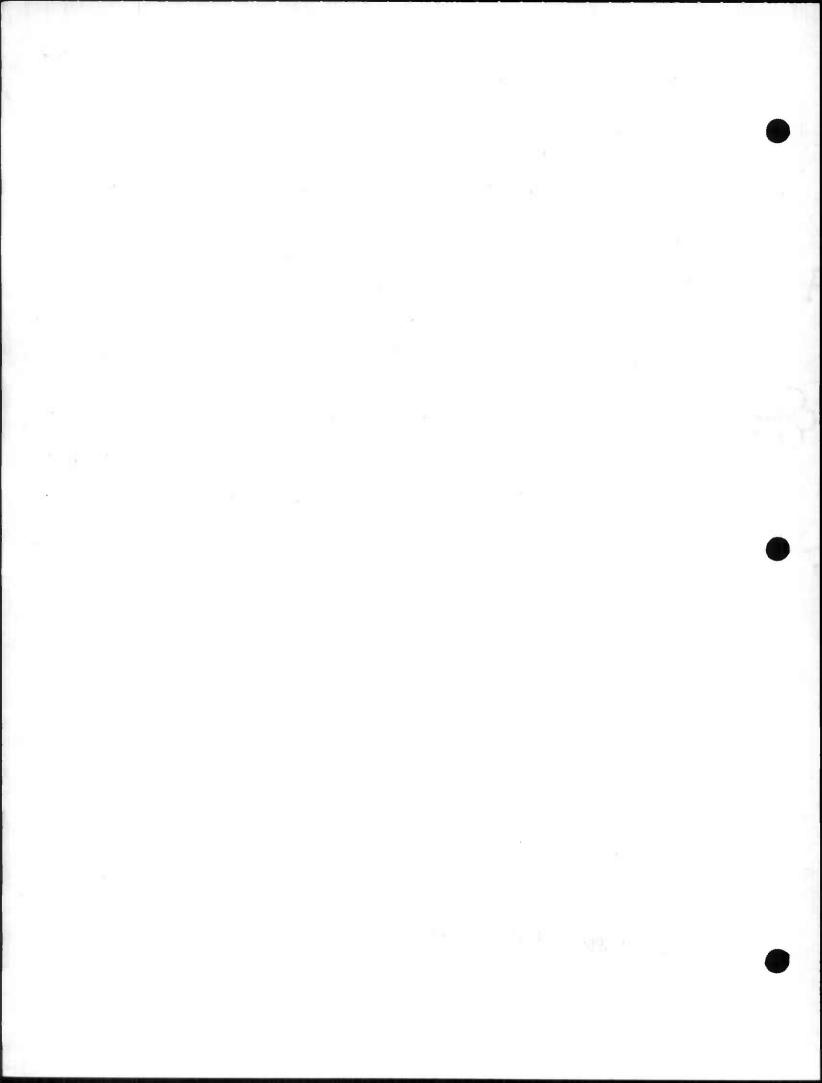
1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH							3. TIME OF DEATH							
	Alice Box				nd				November 17, 1995 10:4			10:45A M		
- 13	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE			6. AGE (In yrs. les	AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 H			7. DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign			
	096 30 4474		1 M 2 #F	85	YRS.	MONTHS	DAYS	B HOURS MIN. 2/2/10					Count	MD.
ا ہ	9e. FACILITY NAME (If not in						b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
DIRECTOR	Maryland		ral Hos	pital		Baltimore City Baltimore			ore City					
<u> </u>	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN O	R LOCA	TION					-	10d. INSIDE CITY
	MD.	BALTO	CITY		E	BALTI	MOR	Ε						# YES 2 NO
FUNERAL	10e. STREET AND NUMBER						10	f. ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
ÿ	1111 PARK	AVE.						217	201				US/	Α
5	11. MARITAL STATUS 1 Never Married 2	Married		YES 2 771	MED NO	1	f yes, sp	ecify Cuba	ιπ, Mexica	NC ORIGIN? (S n, Puarto Rica		or No-	14. RACI Black	E American Indian, k, White, etc.
B⊀	3# Widowed 4 Divo		IF YES, GIVE V	WAR OR DATES		1	YES	2# NO	Specify	<i>y</i> .			AFR.	
COMPLETED	15. DEC (Specify only	EDENT'S EDUC highest grade	CATION completed)	16a. DE	CEDENT'S	USUAL OC	CCUPATIO	ON set of working	na .	16b. KIN	ID OF BUS	INESS/IN		· /IIILICIONIII
9	Elementary/Secondary (0	-	College (1-4 or 5	litte .	Do NOT us	e retired.)	John John	OF OF WORK	·w	н	OSPI	ΤΛΙ		
MP	12		2		R.	N.								
	17. FATHER'S NAME (First, M		OOTE						HER'S NA LANCI	ME (First, Middl	ie, Malden : TES	Sumame)		
BE	190. INFORMANT'S NAME (7		UUIE	19	b. MAILING	ADDRESS	(Street)			Ploute Number, (Ctute 7	n Codel	
2	NINA	ROBERT	S	1						. MD.			apt.	716
	20a. METHOD OF DISPOSITE		oval from State	20b. PLACE	AND DATE O	FDISPOS		_		DATE			City or To	
	4 [#] □ Donation 5 □ Other	(Specify)		MD . N	ATION		ARK		/22/9		LA	JREL	MD.	
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE					ND ADDRE			EDAI	HOM	- D /	,
	leul	U	late	10			STE 130		LAW I	RS FUN PL. BA	LTO.	MD.	212	17
	23. PART. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in desth) a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Approximata interval Between Onset and Death disease or condition and desthing in destrict in destri													
CERTIFICATION	Sequentially list condition in the sequential of the sequence	diate NG ry		(OR AS A CONSEC										
ij			J											
	PART II. Other aignifica			death but not i	esuiting i	n the un	derlyin	g cause (given in	Part I. 24	. WAS AN		24b	WERE AUTOPSY FINDINGS
EDICAL	Diabete	es Me	llitus						PERFORMED?			COMPLETION OF CAUSE OF DEATH?		
Σ	DID TODA GGO III									_	-			1 TES 2 NO
Ä	DID TOBACCO U		SIBUIE TO CA		TH YE			UNC	ERTAI	1				
딣	EXAMINER? 1 YES 2 NO	J MEDICAL	HOSPITAL:			OTHER	R:		-14	- C - C - C				
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TIMI	E OF	28c. INJ	URY AT	sidenca	8 Other (Sp 28d, DESCRI	-	JURY OC	CURED	
BY P		Pending Investigation	(Month, E	ray, reur)	INJ	URY M		YES 2	NO					
	2 Accident Investigation 3 Suicide 8 Could not be detarmined 28s. PLACE OF INJURY — At homa, farm, street, factory, office building, stc. (Specify) 28s. PLACE OF INJURY — At homa, farm, street, factory, office City or Town, State) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)							Route Number,						
COMPLETED	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	ath occurre	d at the ti	ma, data	and place	, and due	to the causels) and man	ner as ste	ted.	
NO N) end manner as stated.
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER					<u> </u>	29c. LICI	ENSE NUN	ABER .		29d. DAT	TE SIGNED	(Month, Day, Year)
2		Sar	S maren	ARWAR	. (RE	SIDE	172	89	234			P 1	1/17	195
	Shakir S	arwar	COMPLETED CAU	SE OF DEATH (ITE	M 27) /7/ne	Print)	-	ener	al :	Hospi	tal			
	31. DATE FILED (Month, Day, NU V 2 V 199	15 jul	34 REGISTRA	R'S IGNATURE				•						



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	Page	al dir	ner
	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	PORTANT: Il item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
ì	sher (the the	lea ea
	OURS	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nedi
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	1 - STATE REGISTRAR	STATE OF MARY			MENT OF H		MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) James	Со	llins	3				of DEATH DA	č17.1		TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 219-18-9157	5. SEX 6. AG 2	E (In yrs. lest 73		IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH h, Day. Year)	8.		CE (State or Foreign
OR	90. FACILITY NAME (If not institution, give st Maryland Gene		ital			nore Ci			Balt		e City
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD	n/a		10c. CITY,	TOWN OR LOCAT	cimore				123	I. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 1929 Ridgehil				101	ZIP CODE 21217			10g. CITIZE		T COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3/12 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 12. FYE IF YES, GIVE WAR OF WWII	S 2 N		If yes, spe	ENDENT OF HISPAI relfy Cuban, Maxica 22 100 Specif	n, Puarto		or No- 14	Black, W Specify:	American Indian, hita, atc. Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION	(Gh	ne kind of wo Do NOT use		st of working	188	D. KIND OF BUS			1
	12 17. FATNER'S NAME (First, Middle, Lest) Noah Collins			5000	el Worl	18. MOTNER'S NA				Ste	ser
TO BE	19a. INFORMANT'S NAME (Type/Print) Idella Stanton	n				nd Number or Aural					216
	20a. METNOD OF DISPOSITION 113 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)		20b. PLACE A	ND DATE OF	DISPOSITION (Na er place)	me of	DAT	E 20c. LO	CATION — CH	y or Town,	Stata
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Moran	^	1001		D ADDRESS OF FA	CILITY				St. BA.MD
CERTIFICATION	23. PART INEAfter the diseases, or one shock, or heart failure. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	S. ASPIRA DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A	tion s a conseo s a conseo	UENCE OF)	ire	de of dying, suc	h es cer	diec or respi	ratory srres	it,	Approximate interval Between Onset and Death Uniknown
A	PART II. Other significent condition New Onset Se	d.				g ceuee given in	Part i.	24a. WAS AN PERFOR	RMED?	AM	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONT	RIBUTE TO CAUSE			NO C	UNCERTAI	N 🗆			1	YES 2 NO
IYSICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 253,40	HOSPITAL:	outpatient 3	□ DOA	OTHER:	e 5 🗆 Residence	-				
BY	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be 28a. DATE OF INJURY At home, farm, street, factory, office building, atc. (Specify) 28b. TIME OF INJURY WORK? 28a. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28a. DATE OF INJURY AT WORK? 1 YES 2 NO 28b. Could not be building, atc. (Specify) 28c. INJURY AT WORK? 1 YES 2 NO 28b. Could not be contained by the contain						ie Number,				
COMPLETED	(ondox only	ICIAN: To the best of my kr									
BE	290. SIGNATURE AND TITLE OF CERTIFIES				, it tily opinion, c	29c. LICENSE NU	MBER	a and place, at	29d. DATE S	SIGNED (M	onth, Day, Year) r17,1995
2	30. NAME AND ADDRESS OF PERSON WA Serena Baraka	at, M.D. c	/o M			neral I	losp	ital			
	31. DATE FILED (Month, Day, Year) NOV 2 0 1995	32. REGISTRAR'S S	CANCELL								



ITEMS: 23 PART I, 27,28a-f, PER MEO FILM G-730 12/13/95 t.t

95 34906

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / I	DEPARTMENT O		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH MONTH D	AY YE	3. TIME OF D	EATH
	WILLIAM	F.	(CURTIS	NOVEMBER		95 7:34	Р.
	216-05-4656 1	SEX 6. AGE (in yrs. lest	YRS. MONTHS D.	NYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1906W	BIRTHPLACE (State of Country)	70
œ	9e. FACILITY NAME (If not institution, give street UNIVERSITY S.T.	,	1	WIN OR LOCATION OF DE FIMORE CI	•	9c. COUNTY	OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT	J •	DAII	THORE CI	11	10	<i> +</i>	
M M	10e, STATE 10b, COUNTY	.] .	10c. CITY, TOWN OR L				10d. INSIDE C	YTK
	Marylano 1	7 R	13a1	TIMUTE			1 TES 2	□ NO
M.	100. STREET AND NUMBER	Clarate		101, ZIP CODE	r	10g. CITIZEN	OF WHAT COUNTRY	Y7
FUNERAL		Street		71716	2		1514	
	11. MARITAL STATUS 12 1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 NO	D If yo	DECENDENT OF HISPAN s, specify Cuben, Mexica	n, Puerto Rican, atc.)	8 or No — 14.	RACE — American I Black, White, etc.	ndlen,
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	10	YES 2 NO Specify	y:		Specify RIA	ok
□	15. DECEDENT'S EDUCAT (Specify only highest grade con		EDENT'S USUAL OCCU	PATION	18b. KIND OF BU	SINESS/INDUS		
L L			re kind of work done durli Do NOT use retired.)	ng most of working	10.4	-		
길	UNKNOWN	Ho	riection	223	MOUIS	E the	aters	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		4	18. MOTHER'S NA	ME (First, Middle, Malden	Surname)		
i w l	UNKHOWN	,		UNK	< P O W N			
TO B	190. INFORMANT'S NAME (Type/Print)	196.	MAILING ADDRESS (S	reet end Number or Rural I	Route Number, City or Tox	m, State, Zip Co	00) 2121	6
	Gloria Duile	9 80	11/Bak	er stree	1 tsalti	MUR	Mary	lano
	20e METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remova	if from State cemetery, crem	ND DATE OF DISPOSITION	N (Name of	1/ LS/9 3	CATION - City	or Town, State	1
	4 Donation 5 Other (Specify)		ALUATY CO	MELLY ME AND ADDRESS OF FA	CILITY	2010	D. Man	Dano
	1 d. 1	4.	4	1	5240	21218	MSI OWN	- un
	Oleany Tr	The	KIH	ATTICAL-	Jams t. 14	. Ralt	hore ne	(21215
	23. PART i. Enter the diseases, or con shock, or heart fallure. Lis	nplications that caused the dea it only one cause on each line.	ith. Do not enter the	mode of dying, auc	h as cardiac or resp	iratory arrest		dmate I Betwean
	IMMEDIATE CAUSE (Final disease or condition	CURCURAL USUATANA					Onset	and Death
	resulting in death) a	SUBDURAL HEMATOMA						
		DUE TO (OR AS A CONSEC	UENCE OF):					
No I	Sequentielly list conditions, b.	DUE TO (OR AS A CONSEC	UENCE OF):					
N N	If any, leading to immediata ceuse. Entar UNDERLYING							
	CAUSE (Diseese or Injury that initiated eventa	DUE TO (OR AS A CONSEC	UENCE OF):					
CERTIFICATION	resulting in death) LAST							
	PART II. Other aignificent conditions of	contributing to deeth but not re	esuiting in the unde	riving cause given in	Part I. 24a, WAS AF	AHTOPSV	24b. WERE AUTOPS	Y EINDINGS
1 % 1		Total and the second second second	and and	injing codes given in	PERFO	RMED?	AVAILABLE PR	IOR TO
MEDIC					1 XYES	2 NO	OF DEATH?	
Σ	DID TOBACCO USE CONTRIE	SUITE TO CAUSE OF DEAT	TH YES I NO	UNCERTAIL			1 YES 2	□ NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		E DF DEATH (Check only				l	
SICI		IOSPITAL: Inpetient 2 ER/Outpatient 3	OTHER:	Home 5 - Reeldence	8 Other (Specify)			
H	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF 28	c. INJURY AT	28d. DESCRIBE HOW	INJURY OCCUR	RED	
BY PF	1 Netural 5 Pending	(Month, Day, Year) UNKNOWN	UNKNOWN	WORK?	SUBJECT FEL	L		
	2XX Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY — At hon building, etc. (Specify)	ne, ferm, strael, factory	office	281. LOCATION (Street City or Town, State		Rural Route Number,	
	4 Homicide determined		HOME		BALTIMORE,			
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowledge, dea	ith occurred at the time	, date end plece, end due	to the ceuse(e) end ma	nner as stated.		
W O	- Control of the Cont	On the beele of examination end/or in					euse(e) end manner	ee steted.
	290 RIGHATURE AND TITLE OF CERTIFIER	1 1		29c. LICENSE NUI	MBER	29d. DATE S	IGNED (Month, Day, Y	ber)
BE	1 Com	- Loren)		O.C.M	1. E.	NOVEM	BER 10	1995
일	THE HAME AND ADDRESS OF PERSON WHO	/						
	JUAKON LOC	32. REGISTRAR'S SIGNATURE	l Penn S	treet, Ba	altimore,	Mary	land 21	.201
	NUV 2 0 1995	in develor Real !!						

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THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed which 24 hours after death. Page 6 may be retained by the hon THE FUNERAL DIRECTIONAL After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacting his distributions after death with the State Dept. On the state and Mental Hygiene prior to buring, removal.

The funeral page 1 is marked for item 23 showe any intury or other page removal the modified as page 1.

DHMH-16 Rev 1/89

216-05-4656 X May 5 1906 Weshington, D.C. Marylano UlA Baltimore 3017 Baker Street 21416 Black Rojectioness UNKHOWN MOVIE TREaters UNKNOWN UNKNOWN 3017 Baker Street Baltimore, Marylono Gloria Bailey 11/15/95 Brocklyn harylono Mt-CALUARY Cemedul They Huis CHATTRA- HAMIS F. IV. BOLKHOK, MI BIDIT-

Pages 1, 2, 3 should permit. use as the burial-transit retained by the hospital or attending physician. for funeral director, page 5 should be detached once. 7 notified hours after death. Page 6 may be pe must examiner filled in by the filon, or removal. medicai other traumatic event, the completely burial, and prior to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be attending phys and any s certificate has been signed by th the State Dept. of Health an id, or Item 23 shows any

BALTIMORE, MARYLAND 21215-0020

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P.O.

DIVISION OF VITAL RECORDS,

DIRECTOR

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69 DIRECTOR: A hours after di item 28 Is

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ITEMS: 23 PART I, 27, 28a-f. PER MEO FILM G-729 11/29/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 LESTER DAVID CANAPP NOV. 14. 12:38 Pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 40 218-66-0849 Jan. 28, 1955 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 21 SOUTH LINWOOD AVENUE BALTIMORE CITY n/a 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland n/a Baltimore 1 YES 2 NO 10e, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 21 South Linwood Ave. 21224 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Married 1 YES 2 NO Specify Specify 3 Widowed 4 Divorced 1975-1979 White 18a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Maintenance Dept. Balt. County Board of Educ. 12 yrs 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Orville Lester Canapp Wood 19a, INFORMANT'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code Ida V. Wood 8109 Dalesford Rd. Baltimore, Md. 21234 20c. LOCATION — City or Town, Stata
Timonium
Timonoim, Md. 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Burial 2 Cremation 3 Ramoval from State Dulaney Valley 4 Donation 5 Nother (Specify) - Fintement 21. SIGNATURE OF TUNERAL SERVICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 ana 23. PART I. Enter the diseeses, or complicate Approximats shock, or heart failure. List only one cause ch lina. Interval Between IMMEDIATE CAUSE (Finsi **Onset and Dasth** disesse or condition . NARCOTIC INTOXICATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in dasth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 SES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 X Xealdence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED FOUNDMAT 1 Netural 5 Pending Investigation 1 YES 2 XXNO UNKNOWN FOUND ON 11-14-95 12:35 PM 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) FOUND AT HOME 281. LOCATION (Street and Number or Rural Boute Number. City or Town, State) Z1 S. LINWOOD AVE. 3 Sulcida SXX Could not be 4 Homicide BALTIMORE, MARYLAND 29a. CERTIFIER
(Chack nnk.)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and pleas, and due to the cause(a) and manner as attend. *** SMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201 O.C.M.E ▶ NOV. 15,1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89

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Pages 1, 2, 3 should

ician.	al-transit perm		
attending phys	se as the buri		
e hospital or	letached for us		ince.
ter death. Page 6 may be retained by the	5 should be d		notified at c
аде 6 тау be	director, page		er must be no
after death. P.	by the funeral	removal.	ical examine
4N: The law requires that the death certificate be executed within 24 hours after	nd completely filled in by the funeral director, page 5 should be detached for use as the burial-trans	emation, or re	natic event, the medical examiner
be executed w	ian and comp	or to burial, cr	aumatic eve
ith certificate	tending physic	al Hygiene pric	or other tr
s that the dea	ned by the at	alth and Menta	any injury,
he law require	has been sig	ate Dept. of Health	d, or item 23 shows any injury, or other traumatic
PHYSICIAN: T	fer this certificate has been signed by the attending physician and	S	rked, or ite
ATTENDING	RECTOR: After	be filed within 72 hours after death with the	TANT: If item 28 is marked
HOSPITAL OR	FUNERAL DIF	within 72 hou	TANT: If ite
TO THE	TO THE	be filed	MPOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH NOV. 16 1995 CHANDLER FRANK 6:44 AM 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
July 24, IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 213-03-0730 1 K M 2 🗌 F 1911 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Greater Baltimore Medical Center Towson Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Cockeysville Md. Baltimore 1 TYES 2 TH NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 21030 13801 York Rd. Unit N-11 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OF DATES Specify: BY 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ast of working COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) General Agent Berkshire Life Ins. Co. 4 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Chandler Graham Meehan James 8 Warren 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 13801 York Rd. Cockeysville, Md. 21030 Mrs. Cecelia S. Chandler 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1 X Burial 2 Cramation 3 Removal from State cemetery, crematory or Immanue1 Episcopal Cem. 11/18/95 Glencoe, Md. Donation 5 Other (Specify) 21. SIGNATURE GE FUNERAL SERVICE DICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 2001 1050 York Rd. Towson, Md. 21204 23. PART LEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata shock, or heart failura. List only ona cause on each line. intarvai Between Onset and Death **IMMEDIATE CAUSE (Final** diseasa or condition Brain Tumer resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, lasding to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avants resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL COMPLETION OF CAUSE 1 - YES 2 1 NO DF DEATH? 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔯 UNCERTAIN 🗆 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:

1X Inpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 2 Accident 5 Pending м 1 YES 2 NO BY Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) S Could not be determined COMPLETED 29a. CERTIFIER
(Check only one)

29 MENICAL EXAMINES: On the best of my knowledge, dash occurred at the time, date and place, end due to the cause(s) and manner as attend. 2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, in my opinion, dash occured at the time, data and place, and due to the cause(a) and manner as steted. 296. SIGNATURE AND TITLE OF GERTIFIER 29d. DATE SIGNED (Month Day Year)

29c. LICENSE NUMBER

03452

ans 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Lamos, M.D. 3346 Papermill Rd.

lark

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11-16

BALTIMORE, MARYLAND 21215-0020 retained by the hospital or attending a should be detached for use as the 24 hours after death. Page 6 may be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL

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29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Mersens models

Pages 1, 2, 3 should

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DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for u		item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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hat	5	hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, cremation, or removal.	À
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Item2 12-1-95 Filmg730 W.H.Per Doctor FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH NOVEMBER # 1995 YEAR SEDORA CHAVEZ -10 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7, DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS MARYLAND 1 M 2 X F 215-30-6059 60 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR N/A UNION MEMORIAL HOSPITAL BALTIMORE CITY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE CITY 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2827 ASHLAND AVE. 21205 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cubsn, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 XMarried 1 TYES 2 NO Specify: Specify: BY BLACK 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) BALTIMORE CITY COMPL 12TH CUSTODIAN N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) CARROLL JACKSON CARRIE BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RAYMOND CHAVEZ 2827 ASHLAND AVE. BALTO, MD. 21205 20a, METHOD OF DISPOSITION

X X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20c. LOCATION — City of Town, State
OWINGS MILLS,
1995 MARYLAND 20b. PLACE AND DATE OF DISPOSITION (Name of DATE GARRISON FOREST Nov. 22, MARYLAND CALVIN B. SCRUGGS FUNERAL HOME al 1412 E. PRESTON ST. BALTO, MD. 21213 23. PART i. Enter the diseases, or complications that caused the das shock, or haart fallure. List only one cause on each line. death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disesse or condition 450 DUE TO (OR AS A CONSCIUENCE OF): resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, isading to immediats cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO CRUNARY VASILIVA BISENSE COMPLETION OF CAUSE OF DEATN? 1 TYES 2 NO Succoma MITTAINE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 Inpetiant 2 ER/Outpetient 3 DOA OTHER:
4 | Nursing Name 5 | Residence 8 | Other (Specify) 1 YES 2 NO 27. MANNER OF DEATH 28b. TIME OF INJURY 28a. DATE DF INJURY (Month, Day, Year) 28c. INJURY ATWAR 28d. DESCRIBE NOW INJURY OCCURED N/OM 5 Pending 1 YES 2 NO BY MA 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide NIA Item 29a. CERTIFIER
(Check only one)

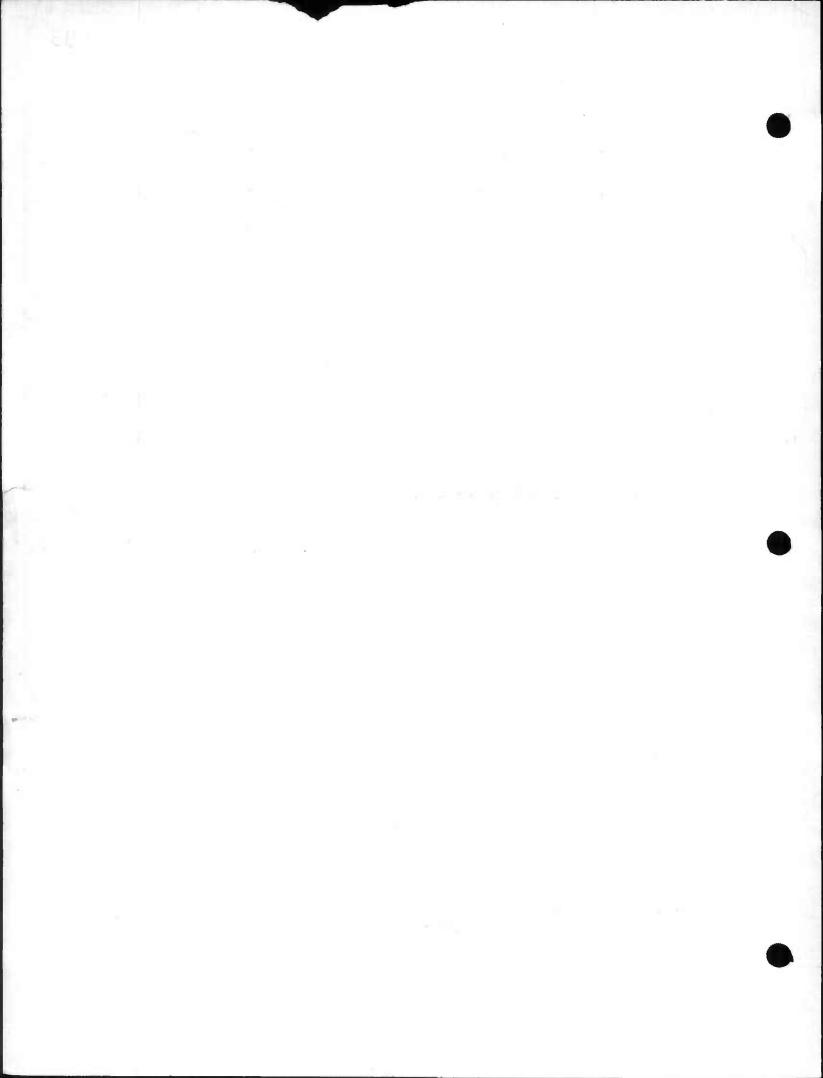
CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL E within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner ee stated, TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

HALLA

29c. LICENSE NUMBER

AT2438946

29d. DATE SIGNED (Month, Day, Year)



BALTIMORE, MARYLAND 212 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the housell or in THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely flied in by the funeral director, page 5 should be detached by fine filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 6876

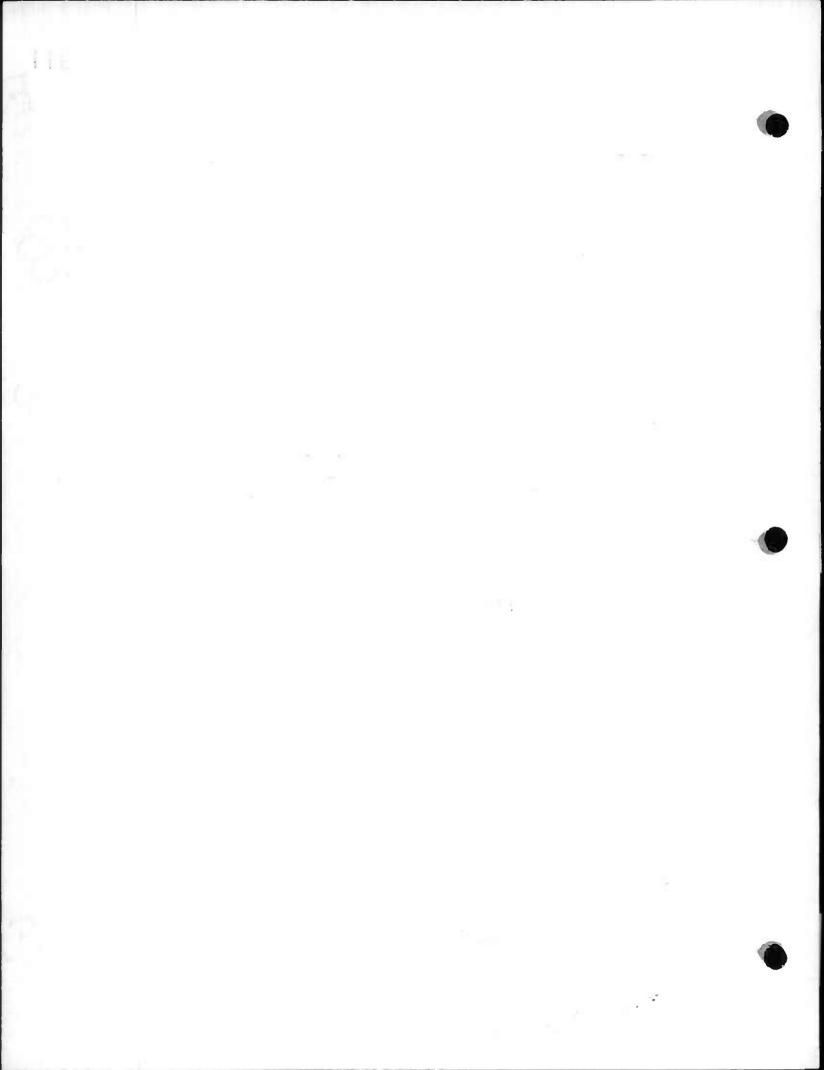
	REGISTRAR		CE	- NIII	CALE	PUEAIR	REG. N	0.		
	1. DECEDENT'S NAME (First, Middle, Last) MARY	WTOMOD TA			CHAMPI	ONT.		DAY 1.C	995	3. TIME OF DEATH 4:58 A.M.M
	4. SOCIAL SECURITY NUMBER	VICTORIA 5. SEX 6.	ACE (la fact		IF UNDER 1 YEA			12		
	244–54–5776	1 M 2 K F	AGE (In yrs. last	YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) 11/3/23		Country	
	9a. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY, TOV	/N OR LOCATION OF DE		9c. COL	UNTY OF DE	Carolina
Œ	4411 LOCH RAVEN				DΛ	LTIMORE C	7.000 2	100		/A
6	RESIDENCE OF DECEDENT	DU V D •			DA	CITHORE C	ITY		TA,	/ 6
DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY	Y, TOWN OR LO	CATION				10d, INSIDE CITY LIMITS?
ă	MARYLAND	N/A			BALT	IMORE				1X YES 2 NO
AL	10e. STREET AND NUMBER			-		10f. ZIP CODE		10g. CIT	TIZEN OF W	VHAT COUNTRY?
FUNERAL	4411 LOCH RAVEN	BLVD.				21218			US	A
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARK	MED		DECENDENT OF HISPAN		ea or No-	14. RACE	— American Indian, t, White, etc.
	1 Never Married 2 X Married	FORCES? 1 [0		, specify Cuban, Mexica YES 2 X NO Specifi			Specif	
ВУ	3 Wildowed 4 Divorced								1	BLACK
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		(Gh	ve kind of v	USUAL OCCUP	ATION most of working	16b. KIND OF B	USINESS/IN	DUSTRY	
91	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT us						
MP	9th GRADE		H	OMEM	AKER		OWN F			
8	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Meid			
BE	SAM SOLOMON						HINE CHEEK			
2	19a. INFORMANT'S NAME (Type/Print)					et and Number or Rural				
	EARLENE GARY		,	4411	LOCH	RAVEN BLVI				21218
	20e, METHOD OF DISPOSITION 1 [XBuriel 2] Cremation 3] Rem	oval from State	20b. PLACE A cemetery, cren		OF DISPOSITION	(Neme of		OCATION -		
	4 Donation 5 Other (Specify)				CEMET		11/11/95	BALI	LIMOR	E, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	0	,		E AND ADDRESS OF FA				
	Mustine .	d. Kop	43			l LOCH RAV		TOWS	SON	MD 21286
	23. PART I. Enter the diseases, or									Approximate
	shock, or heart failure. IMMEDIATE CAUSE (Finel				0		A 0			Onaet and Death
	disease or condition	a. Cerel Arter	mo-V	1as	cula	r aca	dent	•		Galdrut
	resulting in death)	DUE TO (OI	AS A CONSEQ	WENCE OF	F):	^				Bracken
z		Hrtes	rosch	eso	tic C	erebro	vascul	er a	lisea	ise yor.
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate		R AS A CONSEC							
8	cause, Enter UNDERLYING CAUSE (Disease or Injury	с.								
E	thet initieted evente	DUE TO (OF	R AS A CONSEC	DUENCE OF	F):					
H	reaulting in desth) LAST	d								
	PART II. Other significant condition	ns contributing to de	ath but npt re	eaulting	in the under	ving causa givan in	Part I. 24s, WAS	N AUTOPSY	24b	. WERE AUTOPSY FINDINGS
EDICAL						,	PERF	ORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
							1 □ YES	NO		OF DEATH?
Ξ	DID TODA CCO LICE CONT	DIDLITE TO CALL	T OF DEAT	TII VE	.c 🖂 NO	W IIII CEPTAL				1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUS			S NO	7	NLI			
ō	EXAMINER?	HOSPITAL:	-		OTHER:	11				
17S	1 YES 2 NO	1 Inpatient 2 E		28b. TIM	4 Nursing	Home 5 Realdence	8 Other (Specify) 28d. OESCRIBE HON	V IIV II IBV O	CCURED	
	1 Natural 5 Pending	(Month, Day,			JURY	WORK?	266. OESCHIBE HOT	V INSORT O	CONED	
B	Accident Investigation	28a. PLACE OF II	NJURY - At hor	me farm			28f. LOCATION (Stre	at and Numb	er or Rural I	Route Number
	3 Suicide e Could not be 4 Homicide determined	building, ato	. (Specify)	iria, raitti,	anset, rectory,	01110	City or Town, Sta		er or norer r	tode Number,
COMPLET	29a. CERTIFIER				1-1-11-1		1			
AP	(Check only	ICIAN: To the best of my								attech come constant
Ö	2 MEDICAL EXAMINI	IR: On the basis of exam	nination and/or i	nveatigatio	on, in my opinie	on, death occured at the	time, data and place,	and due to	the couse(s	i) end manner as stated.
ш	29b. SIGNATURE AND THE OF CERTIFIE	and Do				29c. LICENSE NU	MBER	29d. DA	TE SIGNED	(Month, Day, Year)
0 8	1.75					D-17	1492		11	8/95.
2	30. NAME AND ADDRESS OF PERSON WE KHIN - M - 7UN	1006 7	AYLO	R A	VENU	E Tows	on ma	21	128	6.
	31. ONOV 2 1995	32 DE GISTRART	प्राप्त महा							

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, in how, after death. Page 6 may be retained by the hospital by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR

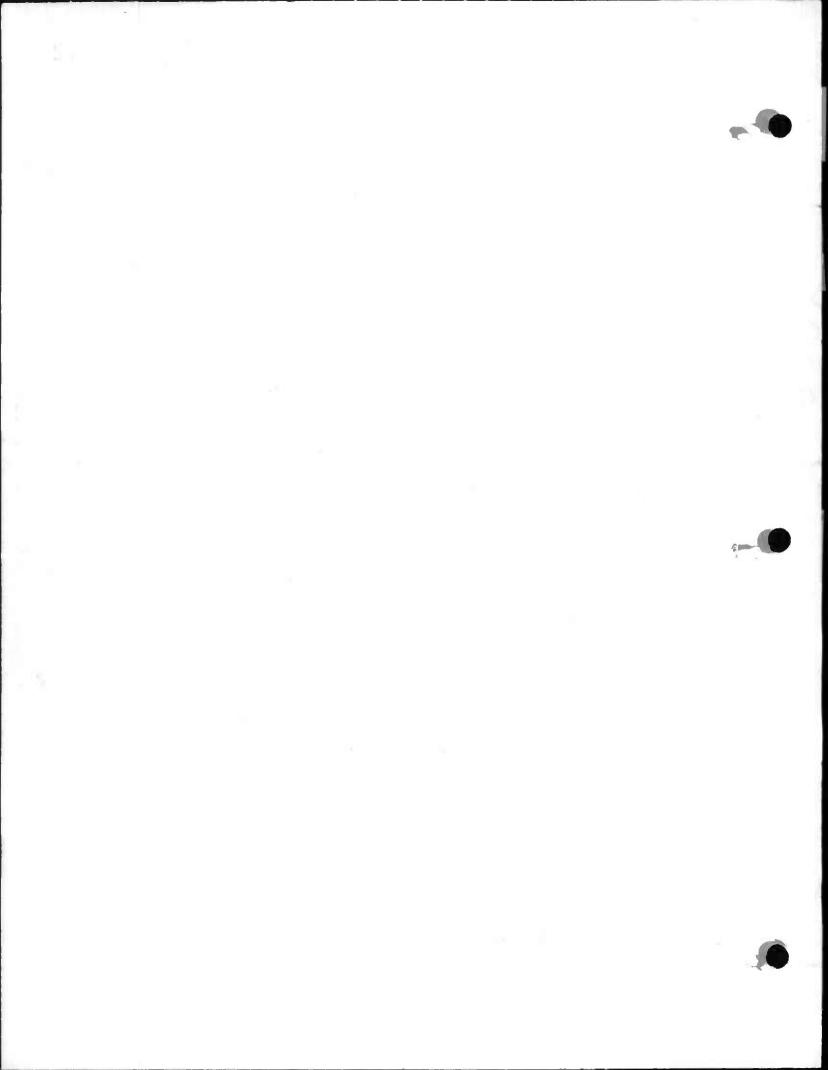
	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
10	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH										
- 0	VIVIAN		DIPANGRA	NOVEMBER 9 1995		95 3:00 Am					
		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)				
131	217-26-2835 1 □ M 2 💢 F	70 yrs.	MONTHS DAYS	HOURS MIN,	Sept. 4,	1925	Pennsylvania				
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF DI			Y OF DEATH				
OH	GREATER BALTIMORE MEDICAL (CENTER	TOWS	ON		BALT	IMORE				
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c CI	Y, TOWN OR LOCA	TION							
DIRECTOR	Maryland Baltimore		1, 10111 011 2001	Dunde	alk		10d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER		10	f. ZIP CODE		10a CITIZE	1 YES 2 NO				
ER/	2963 Cornwall Road			21222			United States				
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER		13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Yes						
ВУ Е	1 Never Married 2 (Merried FORCES? 1 YES		II yes, sp	ecity Cuban, Mexica 2XCYNO Specif	n, Puerto Rican, etc.)		4. RACE — American Indian, Black, White, atc. Specify:				
	3 Wildowed 4 Divorced						White				
E	15. OECEDENT'S EDUCATION (Specify only highest grade completed)	(Ghin kind of	Work done during me	ON ost of working	18b. KIND OF BUS	SINESS/INDU	STRY				
2	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT u			2 -		- 1				
COMPLETED	12 Years 17. FATHER'S NAME (First, Middle, Last)	1 Homes	naker	40 MOTUEDIO NA	ME (First, Middle, Maiden	Home					
	Howard Steele										
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street)		elle Herris Route Number, City or Town		ortel				
임	Mr. Charles DiPangrazio				Dundalk, Mo						
	20a. METHOD OF DISPOSITION 20	b. PLACE AND DATE	OF DISPOSITION /N	ame of	DATE 20c LO	CATION — CI	ty or Town State				
	4 Donation 5 Other (Specify)	TAJ buriari 2 Cremation 3 Hamovai from State Cametery crematory on other place)									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda—Ruck Funeral Home						o of Dundally Inc					
9	THE R		7922	tili so Au	e. Dundall	b Man	uland 21222				
	SART I. Enter the diseases, or complications that cause	d tha daath. Do	not anter the mo	da of dying, auc	h as cardiac or respi	ratory arres	et, Approximata				
	ahock, or heart fallure. List only one cause on a iMMEDIATE CAUSE (Final	each line.					interval Between Onset and Death				
	disease or condition a. PNUNUOVA										
	DUE TO (OR AS A CONSEQUENCE OF):										
2	Sequentially list conditions. To Munic Supression - Ch wire Steroid We										
¥	if any, leading to immediate	A CONSEQUENCE O	F):								
음	CAUSE (Disease or Injury that initiated events	A CONSEQUENCE O	ECUX.								
CERTIFICATION		osteon	opsid	`							
EDICAL	PART II. Other significent conditions contributing to death			g ceuse given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
ă	- GENTLOURIES CULTU	Mallo			1 YES 2	NO	OF DEATH?				
Σ	DID TODA COO LICE CONTRIBUTE TO CALLER						1 TYES 2 NO				
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE C	26. PLACE OF DEA		UNCERTAIL	4 [] [L				
20	EXAMINER? 1 YES NO HOSPITAL: Mospital: Proposition		OTHER:								
H	27. MANNER OF DEATH 28a, DATE OF INJURY	28b, TIN		URY AT	3 ☐ Other (Specify) 28d. DESCRIBE HOW II	WILLIBA OCCIN	BED				
	1 Natural S Pending (Month, Day, Year) 2 Accident Investigation	IN.	JURY WO	PRK? YES 2 NO							
9 ВУ	3 Suicide 280. PLACE OF INJUR	Y — At home, farm,	street, factory, offic	•	281. LOCATION (Street a	and Number or	Rural Route Number,				
凹	4 Homicide determined building, etc. (Spe	эспу)			City or Town, Stete)						
2	29e. CERTIFIER (Check only 1	viedge, death occurr	ed at the time, date	and place, and due	to the cause(e) and man	ner se stated					
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination										
	29b SIGNATURE AND TITLE OF CERTIFIER	HILUPS,	N . 0	29c. LICENSE NUM	/BER	29d. DATE S	GIGNED (Month, Day, Year)				
BE	Homemo (4.C.	THEMES,	(Cur)	0420		▶ 1\	19 95				
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type	Print)	0 -			2 4 4 2				
1	Myc Mullips, No 8	5028 6	tauett	wy ras	aciena, n	so a	UILL				
31. DATE FILED (Month, Day Year) 324 REGISTRAR'S CHATURE											
1	110 6 0 1555										



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1 . STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG.	10.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		EAR 3.	TIME OF DEATH	-
	OLIVIA DOANE					NOVEMBER	10, 19	95	10:04 A	М
	214-40-1220	1 - M 2 X F 5	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPL/ Country)	ACE (State or Foreign	2
<u>~</u>	9a. FACILITY NAME (If not institution, give stre	Juen't		96. CITY, TOWN	11.	82	9c. COUNTY	OF DEAT	тн О	1
6	RESIDENCE OF DECEDENT	4034.100		- Da	Itime	re				
	Md.		10c. CIT	3 11	. 0				LIMITS?	,
NERAL	503 Norma	ndy Ave		10	01. ZIP CODE	1	10g. CITIZEI	S I	T COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 XNO	If yes, a	pecify Cuban, Maxic	en, Puerto Rican, etc.)	Yes or No— 14	RACE — Black, W	American Indian, Thite, stc.	
Ð			16a. DECEDENT'S	USUAL OCCUPAT	ION host of working	16b. KIND OF	BUSINESS/INDUS	TRY	wer	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)	OSC OF WORKING	25.01	Δ.	11.		
OM	17. FATHER'S NAME (First, Middle, Last)	1	(ust	odlan	18. MOTHER'S NA			1 POL	ngs	_
	7 110 11 000	ak			Crai	ce Hen	14			
5	Alternease H.	ardanay	196. MAILING	Kahn	and Number or Rural	House Number, City or	fown, State, Zip Co	120	8	
	20a. MEPHOD OF DISPOSITION 1 Description 2 Cremation 3 Remov		etery, cremetory or of	other plece)	WI.	1.100	1 1	or Town,	Stata	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	1. 000				CH	V CC		
-))	Lime W.	1 c. pa		461	Perkly	esolts the	15 Nim	ve. N	ad. 21215	_
	23. PART I. Enter the diseases, or co- ehock, or heart fellure. Li	mplications that caused at only one cause on ee	the death. Do n	not anter tha me	ode of dying, suc	ch as cardiac or re	apiratory arrest	ia .	Approximate	
	IMMEDIATE CAUSE (Finel disease or condition	Do. la	D. 1.	6	dans					
	resulting in death) a.	DUE TO (OR AS A			acma				30 Minu	4
N	Sequentially list conditions 6.	Myocan	dial	Infair	chim				1 hour	
ATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	F): /						
FIC	CAUSE (Disease or injury thet initieted events	DUE TO (OR AS A	CONSEQUENCE OF	F):						
ERI	resulting in death) LAST									
	PART II. Other eignificant conditions	contributing to deeth bu	ut not reculting !	In the underlylr	ig ceuse given in	Part I. 24a. WAS	AN AUTOPSY	24b. WE	RE AUTOPSY FINDIR	vGS
OCA	As	thma				PERF	ORMED?	COI	MILABLE PRIOR TO MPLETION OF CAUS	
							1/2.10			
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SICI	EXAMINER?	HOSPITAL:		OTHER:		1,000				
Ϋ́Η̈́	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	E OF 28c. IN.	JURY AT		V INJURY OCCUR	ED		_
	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO					
- 1	3 Suicide 8 Could not be datarmined	28e. PLACE OF INJURY - building, atc. (Specif	— At home, term, a fy)	street, factory, offic	ce .	281. LOCATION (Stree City or Town, Sta	et and Number or F te)	Rurel Route	Number,	
APLE	29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIA	AN: To the best of my knowle	edge, death occurre	ed at the time, date	and place, and due	to the cause(s) and n	nenner as stated.			
S	2 MEDICAL EXAMINER:	On the basis of exemination	and/or investigation	n, in my opinion, o	death occured at the	time, data and place,	and dua to the ca	iuse(s) and	d menner as stated	l.
H	296. BIGMATURE AND TITLE OF CERTIFIER	101 -								
2	30. NAME AND ADDRESS OF PERSON WHO'S	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)	250	1343	/VUV	emplo	V 10, 199	5
	KEUN H. SCRUBUS	NO 900	CATON A		BALTIA	work, MA	CHLAND	21	229	
	31 NOV 1 18 1995 July	A REGISTRAR'S IGNY	rupe							
	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED	1. DECEDENT'S NAME (First, Middle, Last) OLIVIA DOANE 4. SOCIAL, SECURITY NUMBER 98. FACILITY NAME (If not institution, give street of the company of the	OLIVIA DOANE a. SOCIAL SECURITY NUMBER DI SERVICIA DOANE a. SOCIAL SECURITY NUMBER DI SELECTION NUMBER S. SEX DI M 2 DF DI DI COUNTY DI M 2 DF DI M 3 DF DI M 3 DF DI M 3 DF DI M 3 DF DI M 3 DF DI M 3 DF DI M 3 DF DI M 3 DF DI M 4 DF DI M 4 DF DI M 4 DF DI M 4 DF DI M 4 DF DI M 5 DF DI	DUDY OLIVIA DOANE 1. SCCLUS SCURITY NUMBER 1. SOCILLY SAME (First, Middin, Lear) OLIVIA DOANE 1. SOCILLY SCURITY NUMBER 1. SOCILLY SAME (In or Institution, of we street and number) STATE 100. STATE 100. STATE 100. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. STATE 100. COUNTY 110. STATE 100. STATE 100. COUNTY 110. STATE 100.	1. DECEDENT'S NAME (First, Middle, Last) OLIVIA DOANE 4. SOCIAL SECURITY NAME (If not institution, give street and number) 9a. PROLUTY NAME (If not institution, give street and number) 9a. PROLUTY NAME (If not institution, give street and number) 9a. PROLUTY NAME (If not institution, give street and number) 9a. STATE 10b. STATE 10c.	US CONTROL DOANS 1 SEX 1 SOCIAL SECURITY NAME (First, Middle, Last) 1 SEX 1	DECEMBER'S MANE (PIST, MASSIS, Last) OLIVIA DONNE 1. SECT. 10. 2 SET 5. SEC 5. AGE (in yrs. last abridge) FURCEL 192A	DECEMBER SHAME (First Modes Last) OLIVIA DOANE 1. SEC. SHAME (First Modes Last) 1. SEC. SHAME (First Mark Modes) 1. SEC. SHAME (First Mark Modes) 1. SEC. SHAME (First Mark Modes) 1. SEC. SHAME (First Modes) 1. SE	DOCUMENT NAME (PAR MARIA (AND CONTROLL AND AND AND AND AND AND AND AND AND AND	SOCIONATY MANUEL PRIVATE MANUEL PRIVATE AND AND AND AND AND AND AND AND AND AND



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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

-	REGISTRAR	ERTIFICA	TE OF	DEATH	REG. NO.		
	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	VENIDA E. DALTON				11/16/95		8:00 A MI
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In	ast birthday) IF UN	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	0. B	IRTHPLACE (State or Foreign
1	216-28-6847 1 M 2 T F 63	YRS. MONTH	HE DAYS	HOURS MIN.	(Month, Day, Year)		ountry)
1	9a. FACILITY NAME (if not institution, give street end number)	9b. C	CITY, TOWN O	R LOCATION OF DE	JAN 3 19	9c. COUNTY O	ARYLAND OF DEATH
E C	701 GEAGDOVE DOAD	CI	I EM DII	DNTE ME		A A	
5	721 SEACROVE ROAD RESIDENCE OF DECEDENT		LEN DU	RNIE, MD		A.A.	
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOW	VN OR LOCATI	ON		_	10d. INSIDE CITY LIMITS?
	MARYLAND ANNE ARUNDEL	GLEN	BURNI	E			1 TYES TO NO
¥	10e. STREET AND NUMBER		101.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
ij.	721 SEAGROVE ROAD		2	1060		U.S.A	
5	11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. A FORCES? 1 YES 2 X	RMED	13. WAS DECE	NDENT OF HISPAN	IC ORIGIN? (Specify Yes	or No- 14. F	RACE — American Indian, Black, White, etc.
BY FUNERAL	1 ☐ Never Merried 2 ☑ Merried FORCES? 1 ☐ YES 2 ☑ IF YES, GIVE WAR OR DATES		1 TYES	2 NO Specify	; Puerto Micim, etc.)		Specify:
							ITE
COMPLETED	(Specify only highest grade completed)	ECEDENT'S USUAL Give kind at work do le. Do NOT use retire	one durina mos	N t of working	16b. KIND OF BUS	NESS/INDUSTR	IY .
2	College (1-4 or 5+)		,		-4		
\ <u>\text{\tint{\text{\tin}\text{\tex{\tex</u>	17. FATHER'S NAME (First, Middle, Last)	SEMBLY W	NORK T				
					ME (First, Middle, Meiden S		
8	GEORGE DTI J.EY 19s. INFORMANT'S NAME (Type/Print)			KATHERI	NE MCGALLE	STER_	
2					loute Number, City or Town		
					BURNIE, M		
	Burlei 2 Cremation 3 Removal from State cemetery, cr	AND DATE OF DISF	ecel			ATION - City o	
	21. SIGNATURE OF FUNERAL SERVING LICENSEE	ON PARK		EKY D ADDRESS OF FAC	1/-20 BAL	TIMORE	, MD.
	10 9-11.		RAYMO	ND C. FI	NK FUNERAL	HOME	
	And day		426 C	RAIN HWY	., S.W., G	LEN BU	RNIE, MD.21061
	23. PART I. Enter the diseases, or complications that coused the d shock, or heart fellure. List only one couse on each lin	eath. Do not en	iter the mod	le of dying, such	as cardiec or respir	atory errest,	Approximate
			1.1	4 .			Interval Between Onset and Death
	disease or condition resulting in death)	static	Non	-small	Cell Carcin	ud Anta	110 Riters
	DUE TO (OR AS A CONSE	EOUENCE OF):				111	1 3/
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Ĕ	if any, leeding to immediate	EOUENCE OF):					
길	CAUSE (Disease or Injury						
	that initiated events resulting in death) LAST	:OUENCE OF):					
CERTIFICATION	d						
	PART II. Other significent conditions contributing to death but not	resulting in the	underlying	ceuse given in i			24b. WERE AUTOPSY FINDINGS
MEDICAL					PERFORM	4.0	AVAILABLE PRIOR TO COMPLETION OF CAUSE
E I						7	OF DEATH?
=	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	ATH YES	Í NO 🏻	UNCERTAIN	<u></u>	`	1 TES 2 NO
Ž.	25. WAS CASE REFERRED TO MEDICAL 26. PLA	CE OF DEATH (Che		OTTOLKITAII			
0 11	EXAMINER?		eck only one)				
Š	HOSPITAL;	OTH	IER:	eV/ Souldson	Other (County)		
HYSI	1	3 DOA 4 1	Nursing Home			JURY OCCURE	
Y PHYSICIAN:	1 VES 2 NO 1 Inpatient 2 ER/Outpatient : 27. MANNER OF OEATH 1. Natural 5 Pending 280. OATE OF INJURY (Month, Day, Year)	3 DOA 4 0	IER: Nursing Home	RY AT	B Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURE	
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Pages 1, 2, 3 should

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH :35 William Cornelius Ennis 1995 November 11, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR | IF UNDER 24 HRS. BIRTHPLACE (State or Foreign Country) 1 X M 2 | F DAYS HOURS 90 579-14-7239 YRS. August 17, 1905 Virginia 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Nursing Center Frederick Frederick RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick 1 YES 2 X NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10a CITIZEN OF WHAT COUNTRYS 400 North Avenue 21701 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES YNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES ZYNO Specify: 14. RACE — American Indian, 1 Never Married 2 Married B 3 XXWidowed 4 ☐ Divorced Snach White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Carpenter Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Luther Ennis Eva Heflin 띪 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6 Cornelius W. Ennis 8614 Linton Hall Road, Bristow, Va. 22013 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 1171 1995 Catlett Cemetery Donetion 6 D Other (Specify) Catlett, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY M00690 Lee Funeral Home of Manassas, Inc. Holvan 8521 Sudley Rd. Manassas, Va. 22110 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata ahock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition PHEUMONIA ASPIRATION 3 DAYS reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): · MULTI-INFARCT + OL ALZHEIMERS TYPE DEMENTIA EARS CERTIFICATION Sequentielly list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL RENAL (MSUFFICIENCY CHRONIC COMPLETION OF CAUSE 1 YES 2 NO DE DEATHS DUSEASE CORONARY ARTERY 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 TYES 2 NO 1 🗍 Inpatient 2 🗎 ER/Outpatient 3 🗍 DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending м 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) L. Kolasteinis ames D20488 11/95 9 30., NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

POBOX 17 MODIETOWN,

MD. 21769

ling physician. the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a found after death. Page 6 may be retained by the hospital or attends	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it	tion, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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ATTEND	E	aff	28
OR ATTEND	DIRECTO	hours aft	Item 28
SPITAL OR ATTEND	VERAL DIRECTO	hin 72 hours aft	VT: If Item 28
HE HOSPITAL OR ATTEND	HE FUNERAL DIRECTO	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	DRTANT: If item 28

	FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI	MENT OF H	EALTH AND N	MENTAL HYG				
	1. DECEOENT'S NAME (First, Middle, L	nst)			DEX.III	2. DATE OF OEAT			3. TIME OF OEATH	
	LYNDA LOUI	SE ECKELS				NOV.		995	5-15 A M	
	4. SOCIAL SECURITY NUMBER		MC	thday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF MONTHS DAYS HOURS MIN. (Month, D.				BIRTH 8. BIRTHPLACE (State of Country)		
	176-38-4160 9e. FACILITY NAME (If not institution, g	1 M 2 F	YRS.	a. CITY, TOWN C		MOORIN, Day, Year) AUG. 18, 1947 PENNSYLVAN Bec. COUNTY OF DEATH				
۳ ا	19311 CHIPPEN		"	HAGERS		AI H	TON			
DIRECTOR	RESIDENCE OF DECEDENT		I so arms				WZIO	111110		
		ASHINGTON		OWN OR LOCAT					10d. INSIDE CITY LIMITS?	
- 1	10a. STREET AND NUMBER	NOTITIO TO N	III		ZIP CODE		10g, CIT	IZEN OF V	1 YES 2X NO	
FUNERAL	19311 CHIPPEN	DALE CIRCLE			21740			USA		
<u> </u>	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEOENT EVER FORCES? 1 YES	IN U.S. ARMED		C ORIGIN? (Specif	E — American Indien, k, White, etc.				
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR		1 TYES	2 K NO Specify:	, , , , , , , , , , , , , , , , , , , ,	~)	Spec		
	15. DECEDENT'S	EDUCATION	18e. OECEDENT'S US	UAL OCCUPATION	N	16b. KIND OI	WHILE			
COMPLETED	(Specify only highest g Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo tired.)	st of working					
MP	12	11	HOMEN	IAKER			ME			
_	17. FATHER'S NAME (First, Middle, Last) RICHARD A. CAI				18. MOTHER'S NAM	J. McKE	22			
H	19e. INFORMANT'S NAME (Type/Print)	AI DELL	19b. MAJLING AO	DRESS (Street a	nd Number or Rural R			Code)		
임	ROBERT T. ECK	ELS			NDALE CI		MD 21740			
	20s_METHOD OF DISPOSITION 1		b. PLACE AND DATE OF D		me of	OATE 20	own, State			
	4 Donation 5 Other (Specify)	Ĭ	IGONIER CE	METERY			LIGONI	ER, 1	PA	
	21. SIGNATURE OF FUNERAL SERVICE	MA //			D ADDRESS OF FAC FUNERAL I		RTINSB	URG.	WV FOR	
	Charles		wa	McCAB	E FUNERAL	HOME,	LIGONI	ER,		
	23. PART I. Enter the diseases, shock, or heert fellu iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Due to (or as	eech line.				respiratory an	rest,	Approximate interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that infiltated events resulting in death) LAST	c	A CONSEQUENCE OF):							
4	PART ii. Other significent condi	tions contributing to death	but not resulting in t	he underlying	ceuse given in F	Part I. 24s. WA	S AN AUTOPSY RFORMED?	24b	WERE AUTOPSY FINDINGS	
							S 2 UNO		AVAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH?	
ME	DID TODA CCO LICE CO.	A PERSONAL PROPERTY AND ADDRESS OF THE PERSONAL							1 TES 2 NO	
AN	DID TOBACCO USE CO		26. PLACE OF DEATH		UNCERTAIN					
2	EXAMINER? 1 YES 2 NO	HOSPITAL:	0	THER:	5 A Reeldence 8	Other /Specific				
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJ	JRY AT	28d. DESCRIBE H		CURED		
2	1 Natural 5 Pending 2 Accident Investigati			M 1 🗆 Y	ES 2 NO					
- 1	3 Suicide 8 Could not 4 Homicide determine	building, etc. (Spe	Y — At home, farm, atred	et, factory, office			281. LOCATION (Street end Number or Rural Floute Number, City or Town, State)			
COMPLETED		HYSICIAN: To the best of my know							e) and manner se stated.	
O BE	296. SIGNATURE AND TITLE OF CERT	meloword	- M.O		29c. LICENSE NUMI				(Month, Dey, Year)	
	30. NAME AND ADDRESS OF PERSON				11 1		1			
	31. DATE FILED (Month, Day, Year)	MCCOMECK 32. REGISTRAR'S SIG	1799 VATURE	Bu	ell Kd	. Hrs	erstown	· · ·	10. 21740	
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REGISTRAR CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Κ. DONALD **ECK** November 16,1995 10:00P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Day, Year) Aug. 20,1931 215-30-2670 HOURS DAYS XX M 2 F YRS. 64 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Balto. City 4819 Bayonne Dr. Apt. B Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore City Baltimore City 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 21206 10g. CITIZEN OF WHAT COUNTRY? 4819 Bayonne Dr. Apt. B USA funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf was apacify Cuben, Mexican, Puerto Ricen, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XIX X YES 2 ☐ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexican, Puerto Rice

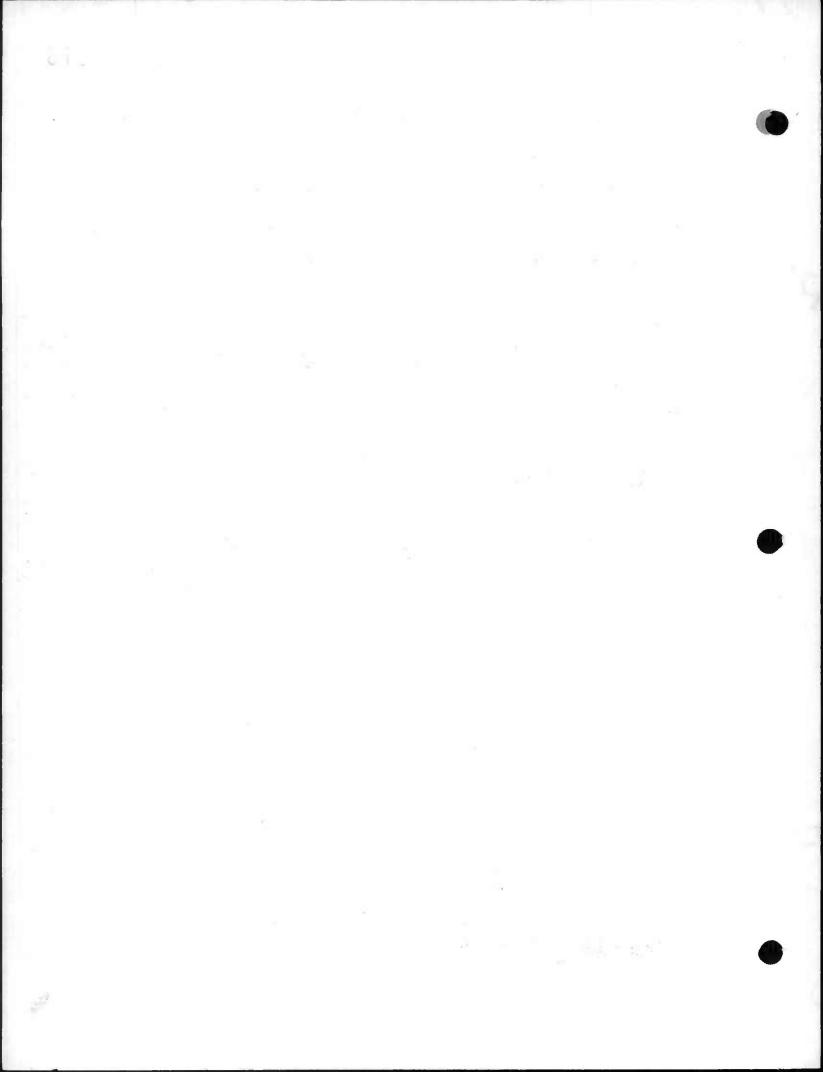
1 YES 2 NO Specify: 1 Never Merried 2 Merried ВУ Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b, KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. N/A Insurance Salesman Insurance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) Melvin Washington Eck Ada May Bell BE notified 19a. INFORMANT'S NAME (Type/Print) 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd. Apt. 4601 Balto., Md. 21234 2 Mr. Robert B. Kelm 9 20a. METHOD OF DISPOSITION
1 Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Parkwood Cemetery 11-20-95 4 Donetion 8 Other (Specify) Baltimore, Md. 22. NAME AND ADDRESS OF FACILITY
Lassahn Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Heather Lasse ampletely filled in by the full cremation, or removal. 7401 Belair Rd. Baltimore, Md. 21236 medicai 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart feliure. List only one cause on each ilns. interval Between IMMEDIATE CAUSE (Finel Onset and Death the disease or condition Chronic Obstructive Lung Disease with Acute browdels I week. resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): 15 years 60 n and con to burial, Smotring Ahuse traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate the attending physician Mental Hygiene prior to prior cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in desth) LAST 0 injury, PART ii. Other algnificent conditions contributing to daeth but not resulting in the undarlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL signed by the any disorder 1 TYES 2 THE Shows 1 YES 2 NO t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN X has b. Dept. PHYSICIAN: 33 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I EXAMINER? HOSPITAL: 4 Nursing Home 5 P Residence 8 Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 10 the 27. MANNER OF DEATH 28b. TIME OF 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, this with 1 Natural 5 Pending 1 YES 2 NO BY After Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 8 Could not be DIRECTOR: J ED 4 Homicide 28 determined COMPLET hours R 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. TO THE HOSPITAL IN THE FUNERAL DE FILE WITHIN 72 PC IMPORTANT: If IN 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 11/17/95 D 21207 9 30. NAME AND ADDRESS OF PERSON WHO-CETED CAUSE OF DEATH (ITEM 27) (Type, Print) 827 LINDEN AVE FRANZ C. VELLA CAMILLERI

M.D

BALTIMORE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

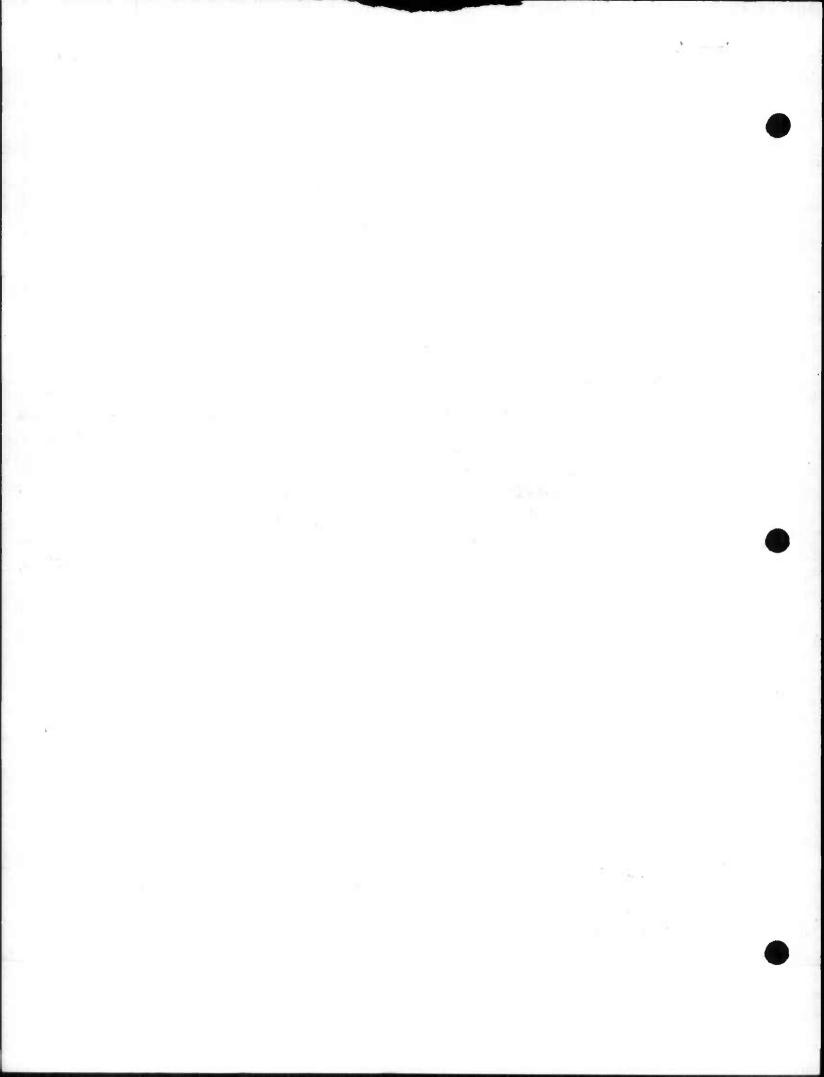
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the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2,		atic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		· · ·									1120. 110.			
	EMZLIE A.				EVERITT NO					.4.1				
	4. SOCIAL SECURITY NUMBER	R	5. SEX		s. last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE C	Ome Money	6.	BIRTHPL/ Country)	ACE (State or Foreign
	213-74-8262 9a. FACILITY NAME (If not ins	titution six at	t M 2 XF	90	YRS.		December 20,1904 Marylan							
E											9c. COUNTY OF CEATH			
5	Good Samari					Baltimore , City						lN/A		
DIRECTOR	Maryland	10b. COUNTY				Baltimore , City						10d. INSIDE CITY LIMITS? 1 TYYES 2 NO		
	10e. STREET AND NUMBER	11//	<u> </u>			αιιι		101. ZIP COO				10g. CITIZEN		T COUNTRY?
FUNERAL	6209 Catalr	ha Ro	ad					21214			U.S			
	11. MARITAL STATUS 1 Never Married 2 1	Married	12. WAS DECEDEN FORCES? 1	YES 2	V NO	13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yes If yes, specify Cuban, Mexican, Puerto Rican, etc.)					Black, White, atc.			
BY	3 X Widowed 4 Divon	ced	IF YES, GIVE W	AR OR OATES		1 ☐ YES 2 📈 NO Specify:							Specify:	ite
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NO N	17. FATHER'S NAME (First, Middle, Last)							18. MOT	HER'S NA	ME (First, M	iddle, Maiden			
BE C	Adolph Zeisel						Caraline Marie Kastle							
10 E	19a. INFORMANT'S NAME (Ty											, State, Zip Co		ALLEY
	Louise M. Tr	Took DI		4377 Northington Drive - Adrain, Michigan 49221										
	1 Burial 2 Cremation 4 Donation 5 Other	cemeter	b. PLACE ANO OATE OF CISPOSITION (Name of netery, cremetory or other place) OATE 20c. LOCATION — City or Town, State 20c. LOCATION — City											
	21. SIGNATURE OF FUNERAL	10 110	22.	NAME	AND ADDRE	SS OF FA	CILITY		l Home	,				
	Konald									ryland 2121				
	23. PART I. Enter the dis shock, or he IMMEDIATE CAUSE (Find disease or condition resulting in daeth)	art fellure.	complessions that List only one ceu	isa Dn each	line.									Approximate Interval Between Onset and Dasth
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST SEPSES DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d.													
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 2								24b. W	ERE AUTOPSY FINDINGS				
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MEC						1 1 455 2 (7.40)						YES 2 PRO		
AN:	DID TOBACCO US		RIBUTE TO CA		PLACE OF OE		-		CERTAI	NOT				
SICI	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	MEUICAL	HOSPITAL:			OTHE	R:	ome 5 🗆 A	anldanna	e [] Other	(Carolle)			
Y PHYSICIAN:	27. MANNER OF DEATH	Pending nvestigation	28e. DATE OF (Month, E	INJURY	28b. TII		28c. I	NJURY AT WORK?				NJURY OCCUP	RED	
TED BY	3 Sulcide 6 0	Could not be letermined		of INJURY — atc. (Specify)	At home, ferm,	street, fac	tory, of	fice			ATION (Street a or Town, Stafe)	and Number or	Rural Rou	te Number,
COMPLET			CIAN: To the best of a										euse(s) a	nd menner as stated.
TO BE	296. SIGNATURE AND TITLE	Ano	luz	M.	D.			P_	O6	-06	4	► NO	VI	onth, Dey, Year)
٦	30. NAME AND ADDRESS OF HAZEM	PERSON WH	NDARY	600	20 5	e, Print)		HOSP.	ITA	76	OF 1	YARY	LAN	O INC.
	31. NOV 200 19	95 g	32.REGISTA	AR'S SONATA	RE									



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALLIMORE, MARTEAND 21215-0020	BALLIMOKE, MAKYLAND 21213-0020
10 THE HUSPITAL DR ATTENDING PHYSICIAN: THE LOW REQUIRES THAT THE UNGUE UP EXECUTED WITHIN 24 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled.	Colorans, the law requires that the beaut certificate or executed within £4 hours after usage of that or retailed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MAR		PARTMEN				NTAL	HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)						2	. DATE	OF DEATH		10000	3. TIME OF OEATH	
	Stanley Art	thur E	VANS	Sr.				Nov	ember		995	3:07 P	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthe		R 1 YEAR	IF UNDER 2	4 HRS. 7	DATE C	OF BIRTH		8. BIRTHI	PLACE (State or Foreign	
	215-10-9102 9a. FACILITY NAME (If not institution, give s	1 X M 2 F	77 YF		DAYS	HOURS R LOCATION		lay	7, 191		Country	Maryland	
OR	Franklin Squa		1	96. (11		ossvi		n		Baltimore			
딦	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	γ	100	10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY			
DIRECTOR	Maryland	N/A		BaltimoreCit								LIMITS?	
FUNERAL	10e. STREET AND NUMBER 472	25Hellwig R	oad	10f. ZIP COOE 21206						United States			
5	11. MARITAL STATUS	12. WAS DECEDENT EVI	R IN U.S. ARMED	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year						or No-	or No — 14. RACE — American Indian, Black, White, atc.		
BY F	1 Never Married 2 X Married 3 Widowed 4 Divorced	ES 2 NO R DATES	NO It yea, specify Cuban, Maxican, Puerto Rican, atc.) 1 YES 2 X NO Specify: Specify										
요	15. DECEDENT'S EDU	CATION	16a. DECEDE	NT'S USUAL (OCCUPATIO	N		16b.	KIND OF BUS	INESS/IN	DUSTRY	···	
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ž	17. FATHER'S NAME (First, Middle, Last)			3-1		40 MOTHS	EDIO NAME	dFirst 4					
		Adolph E	/ans	18. MOTHER'S NAME (First, Middle, Mei Barbara									
H	19a. INFORMANT'S NAME (Type/Print)		MC ADDRES							in Codel			
6	Leona A. Eva			ADDRESS (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 5. Hellwid Doad Raltimore Maryla							nd 21206		
	The state of the s												
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Ramoval from State 4 Donation 5 Other (Specify) Entombment Parkwood Cemetery 11/20/95 Baltimore Maryland												
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		- 00		D ADDRES		tTY.					
	Leonard J. Ruck 5305 Harford Road Baltimore, Md.								k, Inc. d. 21214				
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest,											Approximate	
	shock, or heart failure. List only one fause on each line.											Onest and Deat	
	disease or condition	al infar	nfarction						1 hour				
	readiting in destri)	disease or condition reaulting in desth) Myocardial infarction Due to (or as a consequence of):											
Z	Coronary artery disease												
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2	cause. Enter UNDERLYING CAUSE (Disease or injury												
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H	reaulting in death) LAST												
AL 0	PART II. Other aignificant condition	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY 24b. WE									WERE AUTOPSY FINDINGS		
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Sic	EXAMINER?	HOSPITAL: 1 ☐ Inpatient 2 1 ER/	Outpatiant 3 🗆 De	OA 4 No		a 5 🗆 Rea	idenca 8	☐ Othai	(Specify)				
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BY	1 🔀 Natural 5 🗌 Pending 2 🗎 Accident Investigation	(,		М		'ES 2 🗌	NO						
	3 Suicide 8 Could not be	28e. PLACE OF tN. building, atc.	URY — At home, for	ırm, straet, la	ctory, offic	9	2		ATION (Street a	and Numbe	er or Rural A	Route Number,	
	4 Homicida datermined												
7	29e. CERTIFIER (Check only 1 X CERTIFYING PHYS	SICIAN: To the best of my I	nowledge, death or	curred at the	time, date	and placa,	and due to	the cau	se(a) and mar	nor as at	ated.		
COMPLETED	onel	IER: On the beals of examin	nation and/or invest	Igation, in my	opinion, d	eath occure	d at the tin	ne, data	and place, an	d due to t	the cause(a) and manner so stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE	ER .				29c. LICEI	NSE NUMBI	ER		29d. DA	TE SIGNED	(Month, Day, Year)	
H	1	www	5, ~	0			6116					per 16,1995	
임	30. NAME AND ADDRESS OF PERSON WI												
	Dr. Laurie Harris	9000 Frank	clin Squ	are Dr	. Ва	1timo	re,	Mary	yland	2123	7		
		REG STRAF											
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Grace Helen Friedman 4. SOCIAL SECURITY NUMBER 217-74-9461 9a. FACILITY NAME (if not institution, give street and number) 9a. FACILITY NAME (if not institution, give street and number) Meridian Long Green Nursing Home Baltimore City 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Baltimore City 10c. CITY, TOWN OR LOCATION Maryland N/A Baltimore City 10c. CITY, TOWN OR LOCATION Baltimore City 10d. STATE 10d. COUNTY 10e. STREET AND NUMBER 11. Marital STATUS 1 Never Married 2 Never Married 2 Never Married 3 Never Married 1 Never Married 2 Never Married 2 Never Married 3 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Marrie 1 Never Married 1 Never Married	d. INSIDE CITY LIMITS? YES 2 \sum NO T COUNTRY? U.S.A. American Indian,									
4. SOCIAL SECURITY NUMBER 217-74-9461 9a. FACILITY NAME (if not institution, give street and number) 9a. FACILITY NAME (if not institution, give street and number) Meridian Long Green Nursing Home Baltimore City 10a. STATE 10b. COUNTY Maryland N/A Baltimore City 10c. CITY, TOWN OR LOCATION OF DEATH 10a. STATE 10b. COUNTY Maryland N/A Baltimore City 10c. CITY, TOWN OR LOCATION Baltimore City 10c. CITY, TOWN OR LOCATION 10c. STREET AND NUMBER 10d. STATE 10d. STATE 10d. STATE 10d. STATE 10d. COUNTY Maryland N/A Baltimore City 10d. CITY, TOWN OR LOCATION 10d. STATE 10d. CITY, TOWN OR LOCATION 10d. STATE 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. STATE 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. STATE 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION 10d. CITY TOWN OR LOCATION 11d. RACE 11d. MARITAL STATUS 11d. MARI	d. Inside crty LIMITS? Yes 2 \square No T COUNTRY? U.S.A. American Indian, hita, stc.									
4. SOCIAL SECURITY NUMBER 217-74-9461 1	d. Inside crty LIMITS? Yes 2 \square No T COUNTRY? U.S.A. American Indian, hita, stc.									
Second Process Seco	d. INSIDE CITY LIMITS? YES 2 \(\text{NO}\) T COUNTRY? U.S.A. American Indian, hits, etc.									
Meridian Long Green Nursing Home Residence of decedent 10a. State 10b. county Maryland N/A Baltimore City 10c. city, town or location Maryland N/A Baltimore City 10b. city town or location 10c. city, town or location 10c. city, town or location 10c. city, town or location 10c. city 10d. city 10d. city 10d. city, town or location 10d. city 10d. city 10d. city 10d. city, town or location 10d. city 10d. city 10d. city, town or location 10d. city 10d. city, town or location 10d. city 10d. city, town or location 10d. city 10d. city, town or location 10d. city, town or location 10d. city, town or location 10d. city, town or location 10d. city, town or location 11d. city 11d. city 12d. was decendent of hispanic origin? (specify Yea or No— 11d. race— Black, w 11	d. INSIDE CITY LIMITS? YES 2 NO T COUNTRY? U.S.A. American Indian, hita, etc.									
10e. STREET AND NUMBER 115 E. Melrose Avenue 121212 11. Marital Status 1 Never Married 2 Merried 3 M Widowed 4 Divorced 12 Never Married 2 Merried 3 M Widowed 4 Divorced 16 Decedent's Education (Give kind of work done during most of working life. Do Not use refired.) 16 Decedent's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname) 19. Z1212 19. Was Decendent of Hispanic Origin? (Specify Yea or No— Id. Race—Black, W Specify: 11 Yes, specify Cuben, Markcan, Puerto Rican, etc.) 12 Yes 2 No Specify: 13. Was Decendent of Hispanic Origin? (Specify Yea or No— Id. Race—Black, W Specify: 14. Race—Black, W Specify: 15 Decedent's Education (Give kind of work done during most of working life. Do Not use refired.) 16 Nother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Maiden Surname) 18. MOTHER'S Name (First, Middle, Maiden Surname) 19. Z1212 19. Was Decendent of Hispanic Origin? (Specify Yea or No— Id. Race—Black, W Specify: 10 Yes, specify: 11 Yes, specify Cuben, Markcan, Puerto Rican, etc.) 12 Yes 2 No Specify: 13. Was Decendent of Hispanic Origin? (Specify Yea or No— Id. Race—Black, W Specify: 14 Yes, specify Cuben, Markcan, Puerto Rican, etc.) 15 Homemaker 16 Homemaker 17 Father's Name (First, Middle, Maiden Surname) 18 Nother's Name (First, Middle, Maiden Surname) 18 Nother's Name (First, Middle, Maiden Surname) 19 Nother's Name (First, Middle, Maiden Surname)	d. INSIDE CITY LIMITS? X YES 2 \(\text{NO}\) NO T COUNTRY? U.S.A. American Indian, hits, stc.									
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16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Homemaker 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker 17. FATHER'S NAME (First, Middle, Lest) unknown 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16c. MOTHER'S NAME (First, Middle, Malden Surneme) Rose	White									
unknown unknown Rose										
unknown unknown Rose										
unknown unknown Rose	100									
unknown unknown Rose										
	ınknown									
Thomas V. Friedman 401 Hollen Road, Baltimore, Maryland 2121	2									
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of cametary, crematory or other place)	Stata									
Dulaney Valley Memorial 118 Lutherville, 1	Maryland									
21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home										
6500 York Rd. Baltimore, Maryland	d 21212									
23. PABY I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition security or cause on a cause on each line. A Z Ne M C S D S C C	Approximata Interval Between Onset and Death									
DUE TO (OR AS A CONSEQUENCE OF):	7,3,									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d.										
Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in dasth) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): 24b. WILLIAM OF THE CONSEQUENCE OF): 24c. WAS AN AUTOPSY 24b. WILLIAM OF THE CONSEQUENCE OF): 24c. WAS AN AUTOPSY 24b. WILLIAM OF THE CONSEQUENCE OF):	ERE AUTOPSY FINDINGS									
Typertensish Performed? 1 U yes 2 MNO OF	MALABLE PRIOR TO OMPLETION OF CAUSE									
	DEATH?									
10										
- ·	25. WAS CASE REFERRED TO MEDICAL									
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 pertient 2 ER/Outpatient 3 DOA 4 Norsing Home 5 Residence 6 Other (Specify)										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 M NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Dey, Year) 28b. Time OF INJURY WORK?	9									
2 Accident Investigation	te Number									
2 Accident Investigation	ie Number,									
2 Accident Investigation										
Comparison of the control of the c	nd manner as stated.									
Accident Second	nd manner as stated.									
Total Control of the Control of th	nd manner as stated.									

FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CE		CATE O			MENIAL	REG. NO.	_			
1. DECEDENT'S NAME (First, Middle, Last)	-						2. DATE O				3. TIME OF DEATN	
Richard V. FIT	ZGERALD						Nove	mber	17,	1995	1:11 pm w	
4. SOCIAL SECURITY NUMBER	5. SEX 8	. AGE (In yrs. les		IF UNDER 1 YEA			7. DATE OF	F BIRTH		8. BIRTH	PLACE (State or Foreign	
183-14-2648	1 🕅 M 2 🗆 F	71	YRS.	MONTHS BAY	'S HOURS	MIN.	JUNE	11,19	924	Penn!		
9a. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY, TOW		ON OF DE				JNTY OF D	EATN	
Franklin Square H	ospital			Balti	more				Balt	imor	e County	
10a. STATE 10b. COUNT			10c. CITY	TOWN OR LO	CATION						10d, INSIDE CITY	
Maryland Balti	more			, 101111 011 20		timo	re			1	LIMITS?	
10e. STREET AND NUMBER					10f. ZIP COD			_	10a CI	TIZEN OF V	1 YES 2 NO	
8 Nerbay Road				ł		1221				USA	THE COURT IN	
11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 12	EVER IN U.S. ARI	MED	13. WAS 1	DECENDENT O	OF NISPAN	IIC ORIGIN?	(Specify Yes	or No-	14 BACE	- American Indian,	
1 Never Married 2 Married 3 Widowed 4 Divorced	specify Cubs			can, etc.)		Black	white, etc.					
	l WW I	Ι.						40			wiitre	
15. DECEDENT'S EDU (Specify only highest grade	completed)	(Gi	CEDENT'S L ve kind of wi Do NOT use	SUAL OCCUP	ATION most of workli	ng	16b. K	IND OF BUS	INESS/IN	DUSTRY		
Elementary/Secondary (0-12)	College (1-4 or 5+)		e Fit	,			P1	umbin	o Tr	duet	rv	
Pipe Fitter Plumbing Indus 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname)										Idasc	1.9	
Joseph Edward Fitzgerald Vivian Cellshire									ro			
19a. INFORMANT'S NAME (Type/Print)			MAILING	ADDRESS (Stre	et and Number							
Dorothy Caroline	Maykrantz			oay Rd						,,		
20a. METNOD OF DISPOSITION 1 ☐ Burlal 2X☐ Cremation 3 ☐ Ram		20b, PLACE A	ND DATE OF	F DISPOSITION	/Name of		DATE	_		City or To	wn, State	
4 Donation 5 Other (Specify)	DVIII from State	Metro	Crem	atory,	Inc. 1	1/20	0/95	Ba1	timo	re, l	MD	
21. SIONATURE OF FUNERAL SERVICE LIC	ENSEE FRANT F	. McDor	nald.		AND ADDRE							
+ Almya	Natona	ilat	IGIG	299	ation <u>Frede</u> r	rick	Rd F	OI Ma Saltim	iryra	and,	1nc.	
23. PART I. Enter the diseases, or	complications that c	aused the de	nth. Do no	ot enter the	mode of dy	ing, suci	h aa cardia	c or reapir	atory e	reat,	Approximate	
ahock, or heart failure. IMMEDIATE CAUSE (Finel	List only one cause	on each line.							ester an	,	Interval Between Onset and Death	
	. Acute My	ocardia	ardial Infarction									
Touching in death)	DUE TO (O	R AS A CONSEO	UENCE OF)	:							l hour	
Sequentially list conditions,	Atherscl				ular I)isea	ase				61 years	
if any, leading to immediate	DUE TO (OI	R AS A CONSEO	UENCE OF)	:								
CAUSE (Disease or injury	e	R AS A CONSEO	(IENCE OF)	or on								
that initiated events resulting in death) LAST	200 10 (0)	n AS A CONSEC	DENCE OT):									
	d											
PART II. Other aignificent condition	a contributing to de	eth but not re	suiting in	the underly	ing ceuse (given in	Part I. 2	4s. WAS AN A		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
							_ ?	YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?	
				XX			_				YES 2 NO	
DID TOBACCO USE CONTI	RIBUTE TO CAUS					ERTAIN	1 🔲					
EXAMINER?	HOSPITAL:			OTHER:					-			
27. MANNER OF DEATN	26e. DATE OF IN.		28b. TIME	OF 260	INJURY AT	sidence			HIPM OF	O I I I I I		
Natural 5 Pending	(Month, Day,		INJU	RY	WORK?	NO.	260. DESCR	RIBE HOW IN	JUHY OC	CORED		
2 Accident Investigation 3 Suicide 6 Could get be	28e. PLACE OF II	NJURY — At hon	ne, farm, st				261. LOCATI	ON (Street ar	nd Numbe	r or Bural B	cute Number	
4 Homicide determined	building, etc	: (Specify)					City or	Town, State)			outo Hamber,	
29a. CERTIFIER 1 X CERTIFYING PHYSI	CIAN: To the best of my	knowledge des	th occurred	l at the time of	eta and alass	and due		4-3 4				
(Check only one) 2 MEDICAL EXAMINE											and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIES				-	-	NSE NUM		, .,			(Month, Day, Year)	
Colot.	no	>				1917	10/5.11				er 17, 1995	
30. NAME AND ADDRESS OF PERSON WH											,	
John Kim, M.D. 9	000 Frankl	lim Squ			Balti	more	, Md	21237				
NOV 2 0 1995	A PLUMBAR N	SIGNATURE										

DHMH-16 Rev 1/89

IMPORTANT. If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876(
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed when TN hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR	5	STATE OF I	MARYLA				HEALTH AND I	MENTA	L HYGIEN				
1. DECEDENT'S NAME (First,	Middle, Last)					7 (I E O)	DEP(III	2. DATE	OF DEATH			3. TIME OF DEATH	
FAYETTE	FOSTER	FREE	AND					NOM	EMBER	14.	1995	7:14P.M.	м
4. SOCIAL SECURITY NUMB	ER 5.	SEX		n yrs. last	birthday) III	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	1-1/	8. BIRTH	PLACE (State or Foreign	-
213-09-8219	7	M 2 F	88	32	YRS.	DAYS DAYS	HOURS MIN.	2	th, Day, Year) /6/13	In an		ARYLAND	_
ST. JOSEPH	HOSPITA	,			9		OR LOCATION OF DE ISON	EAIH			INTY OF D		
RESIDENCE OF DEC	10b, COUNTY				10c CITY I	OWN OR LOCA	TION					10d. INSIDE CITY	=
		MODE			100. 0111, 1							LIMITS?	
MARYLAND 100. STREET AND NUMBER	BALTI	MORE				PARKVI	LLE N. ZIP CODE			100 CC	TIZEN OF V	1 YES 2 NO	-
1818 ABERDE	מגסת זאינוים									log. G			
11. MARITAL STATUS		. WAS DECEDEN	T EVER IN	U.S. ARM	ED	13. WAS DE	21234 CENDENT OF HISPAI	NIC ORIGI	N? (Specify V	s or No-	US/	- American Indian.	\dashv
1 Never Married 2 X		FORCES? 1	X YES	2 NO		II yes, s	pecify Cuban, Mexico S 2 NO Specif	n, Puerto			Speci	k, White, etc.	- 1
3 Widowed 4 Divo	rced		WW	-			X. C GDOOM	,				HITE	
15. DEC (Specify only	EDENT'S EDUCATE y highest grade com	ON pleted)		(Giv	kind of wor	SUAL OCCUPAT		16	b. KIND OF BU	JSINESS/IN	DUSTRY		\neg
Elementery/Secondery (0		ollege (1-4 or 5	+)	life. i	Do NOT use r	etired.)							
		YEARS		SA	LESMA	N				EWAR	ES		
17. FATHER'S NAME (First, Middle, Last)							18. MOTHER'S NA	AME (First,	Middle, Maide	n Surname)			
FAYETTE FF		REELANI							AY FOS				_
190. INFORMANT'S NAME (7							and Number or Rural	Route Nun	nber, City or To	wn, State, Z	(ip Code)		
THERESA FR			1000						TMORE.		2123		_
20e. METHOD OF DISPOSIT	n 3 🗆 Removal	from State			ND DATE OF atory or other	DISPOSITION (A r place)	lame of	DA	TE 20c. L	OCATION -	- City or To	own, Stete	ij
4 Donation 8 Other 21. SIGNATURE OF FUNERA			DU	LANE	Y VAL		M. GAR.		17/95	COC	KEYSI	TILLE, MD	\dashv
21. SIGNAL OF FUHER	11	-	_				SON FUNE		HOME				- 1
1	1					8521	LOCH RA	VEN	BLVD.	TOW	SON,	MD 21286	
IMMEDIATE CAUSE (Fir	aert fallure. List	plications the only ona ca	t ceused use on ea	the dee	th. Do not	enter the m	ode of dying, auc	ch as cer	rdlec or rea	piretory e	rreat,	Approximate Interval Betwee Onset and De	
disease or condition resulting in death)	→ e					AORTI	C ANEURY	SM					
		DUE TO	(OR AS A	CONSEO	JENCE OF):							1	- 1
Sequentially list condit if any, leading to imme cause. Enter UNDERLY	diate	DUE TO	(OR AS A	CONSEQ	JENCE OF):								
CAUSE (Diseasa or Inju		DUE TO	(OR AS A	CONSEC	JENCE OF):								-
thet initieted events resulting in death) LAS	т	DOE 10	(On AS A	CONSEC	DENCE OF J.								- 1
	d				-							-	
PART II. Other significa	ent conditions c	ontributing to	death be	ut not re	sulting in	the underlyl	ng ceuse given in	Part I.		PRMED?	246	WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									1 TYES	NO NO		OF DEATH?	
DID TOBACCO U	ISE CONTRIB	LITE TO C	UISE O	E DEAT	L VEC		J UNCERTAL	NI NT				1 TYES 2 XNO	
25. WAS CASE REFERRED T		OIE IO CA				(Check only one		ואָן וּאו	1				_
EXAMINER?	Н	OSPITAL:				THER:		0 _ 5					
1 X YES 2 NO	1	28e, DATE O	_	etlent 3	28b. TIME	7	me 5 Residence		er (Specify)	IN HIDY O	CCUBED		\dashv
	Pending		Day, Year)		INJUF	RY W	ORK?	20g. Di	SCHIBE HOW	INJUNT O	CCUMED		- 1
2 Catata	Investigation	28e. PLACE	OF INJURY	— At hor	e term etr	eet, fectory, aff		281 1.0	CATION (Stree	t and Numb	or or Rumi	Bouts Number	\dashv
	Could not be determined	building	etc. (Spec	cify)	,	, , , , , , , , , , , , , , , , , , , ,			y or Town, Stat		0. 110.07	Total Hallow,	
29e. CERTIFIER						SW12277 20							\dashv
(Check only							te end place, end du					e) end menner ee stated	.
			- Indiana	1 4110/01 11	iveatigation,	in my opinion,	-		te ena piece, i	_			
296. SIGNAPORE AND TITLE	OF CERTIFIER	10	- 1		1	de	SIN FICEHOE NO	MOCR C	>-	29d. D/	TE SIGNED	(Month, Day, War)	-
20 NAME AND ADDRESS	West .	19	20	25	rel	CIRC	11509	90	2	10	1-15	5 75	_
30. NAME AND ADDRESS O							Led Deol	timo	ro Mr) 11	210		- 1
31 DATE SHED (Month Cont	WALL A	32 Mars		т пс	штес	TITIT P	wau bal	CIIIO	re, M	<i>J</i> ZI	210		
NOV 2 UT	195 /1	N. WILLIAM											- 1

DHMH-16 Rev 1/89

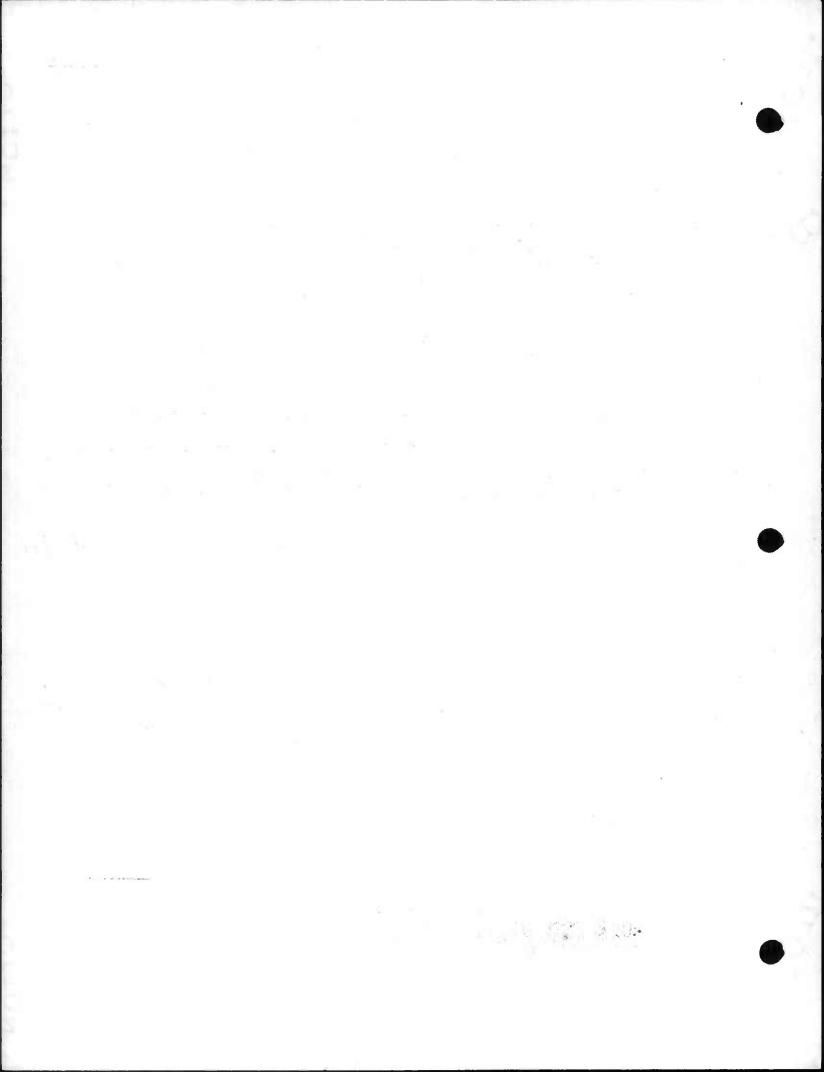
I or attending physician. for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death cardificate be executed within a hours after death. Date 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral direction page 5 should be detached to	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIEN
	CE	ERTIFICATE	OF DEAT	ГН		REG. NO.

ENT OF HEALTH AND MENTAL HYGIENE ATE OF DEATH REG. NO.							
2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH							
NOVEMBER 9,1995 2:00PM M NDER 1 YEAR IS UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign							
Maryland Mars Min. Mars 89, 1930 Country)							
CITY, TOWN OR LOCATION OF DEATH BALTIMORE COUNTY BALTIMORE BALTIMORE							
WN OR LOCATION 10d. INSIDE CITY							
Saltimore County 1 ☐ YES 2√X NO							
101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21236 USA							
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: WHITE							
M. OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY							
aminer- ment Ins. State of Maryland							
18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Lena Valenti							
RESS (Street and Number or Aural Acute Number, City or Town, State, Zip Code) .ater Avenue Baltimore, Md. 21236							
Paith Cem. 11-13-95 Baltimore, Md.							
22. NAME AND ADDRESS OF FACILITY I A CC ALIAI ETINIED AT LIOME TAIC							
LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE,MD. 21236-4625							
ntar the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between							
Corne freein 10/276/94							
Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):							
B underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS							
PERFORMED? 1 YES 2 M MO AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
NO UNCERTAIN							
neck only one)							
HER: Nursing Home 5 € Residence 8 □ Other (Specify)							
28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED t YES 2 NO							
factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
the time, data and place, end dua to the cause(a) and manner ea stated.							
my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.							
29c. LICENSE NUMBER 29d. DATE SIGNED (Morth 2017) 95							
10, MD 21237							



STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

EDITH

217-18-3196

9a. FACILITY NAME (If not institution, give street and number)

4. SOCIAL SECURITY NUMBER

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BAYVIEW MEDICAL CENTER DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION MARYLAND N/A BALTIMORE CITY 101. ZIP CODE 21213 FUNERAL 10e. STREET AND NUMBER 1208 N. DECKER AVENUE hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X 11. MARITAL STATUS 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 3 Widowed 4 Divorced BY ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Sp ntary/Secondary (0-12) College (1-4 or 5+)
N/A COMPL CUSTODIAN once. 17. FATNER'S NAME (First, Middle, Last) JOSHUA COOPER notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 VAIMARIE JOHNSON 9 20b. PLACE AND DATE OF DISPOSITION (Name of must 4 Donetion 5 Other (Specify) BALTIMORE NATIONAL CEM NOV examiner 21/SIGNATURE OF FUNERAL SERVICE LICENT 22. NAME AND ADDRESS OF FACILITY n and completely filled in by the to bunial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disesse or condition resulting in death) METASTATIC BEGAST CARLUNOMA traumatic event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior death certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the MEDICAL been signed by the ACUTE RENAL AT YPERTENSION - EDILURE that shows any requires MELLI 7US DIABETES DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN PHYSICIAN Dept. MP 23 has 26. PLACE OF DEATN (Check only or 25. WAS CASE REFERRED TO MEDICAL State Item certificate **EXAMINER?** OTHER: 1 - YES 2 NO 1 Dopatient 2 ER/Outpatient 3 DOA PHYSICIAN: 4 Nursing Nome 5 Residence 6 Other (Specify) the 6 26e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF GEATN Natural 26b. TIME OF 28c. INJURY AT WORK? this c marked, 5 Pending Investigation 1 YES 2 NO L DIRECTOR: After the hours after death w item 28 is mark BY Accident OR ATTENDING 28s. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

2 MEDICAL EX MINES: On the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. FUNERAL (= 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 15 29b. SIGNATURE AND TITLE OF CERTIFIED 29c, LICENSE NUMBER BE 95012 landereures

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jalia d'Audion Ravielle

GRINAGE

78

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH YEAR 95 08.45" 193 11 7. DATE OF BIRTN IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign FEB 6,1917 MARYLAND 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE CITY N/A 10d. INSIDE CITY 1X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-14. RACE --- American indian, Black, White, etc. BLACK 16b. KIND OF BUSINESS/INDUSTRY BALTO. CITY DEPT. ED. 16, MOTNER'S NAME (First, Middle, Malden Surname) EMMALINE QUICKLEY 2926 MC ELDERRY ST. BALTO, MD. 21205 20c. LOCATION — City or Town, State DATE BALTO MD. CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 Approximata Interval Batween Onset and Dasth 445 24e. WAS AN AUTOPSY 24h WERE AUTOPSY EINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | 10 OF DEATH? 1 YES 2 NO 28d. DESCRIBE NOW INJURY OCCUREO

29d. DATE SIGNED (Month Day Year)

D 11

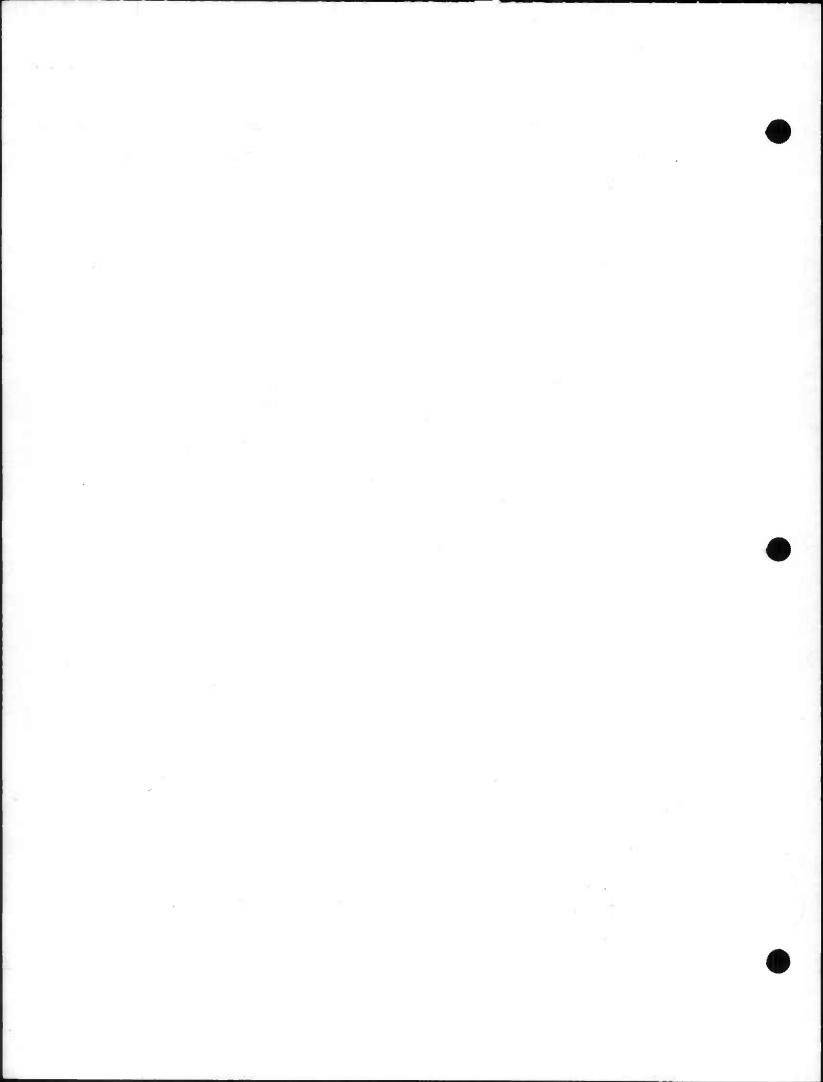
Bry View Med. Center

118195

DIVISION OF VITAL RECORDS, P.O. BOX 6876

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAR		C	EKIIFI	CALE	: OF	DEA	IH	RE	G. NO.				
9	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DI	DAY	·	YEAR	3. TIME OF DEATH	
	WILLIAM 4. SOCIAL SECURITY NUMBER	DAI 5. SEX 8.	G() AGE (In yrs. la	ODWI				NOV				8:30 PM		
	579-98-2987	1 X M 2 🗆 F	3 4	YRS.	MONTHS	DAYS	HOURS	MIN.	APR. 1	4, 1	964	count Ca	MPLACE (State or Foreign mbodia	
OR	9a. FACILITY NAME (if not institution, give street and number) 343 WEST SIDE DRIVE						OR LOCATI		EATH			NTY OF D	eath)MERY	
اق	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v												
DIRE	Md. Montgomery				ther								10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL DIRECTOR	100. STREET AND NUMBER 1004 Travis Lane					10	r. zip cod 20	€ 0878			-		odia	
BY FUN	t1. MARITAL STATUS t X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT E FORCES? 1 I IF YES, GIVE WAR	YES 2 X		11	f yes, sp		ın, Mexice	NIC ORIGIN? (Sp in, Puerto Rican, y:		or No—	Spec	E American Indien, k, White, etc. ify: nbodian	
	ts. DECEDENT'S EDU	CATION	18a. O	ECEDENT'S	USUAL OC	CUPATI	ON		16b. KIND	OF BUS	INESS/IN		IDOUTALL	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4 or 5+)	III.	Give kind of w e. Do NOT us ainte	e retired.)	luring m	ost of worki	ng	Co	nstr	ucti	on		
MO	17. FATHER'S NAME (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·					18. MOT	HER'S NA	ME (First, Middle					
BE C	Arthur Goodwin	1					*******			ainable)				
TO B									Acute Number Cl				4233	
	20a. METHOD OF DISPOSITION 1 Graph Stone 3 Graph 4 Donellon 5 High ther (Specify)	noval from Stale	20b. PLACE cemetery, cr	AND DATE OF OR	of Disposi	ITION(N	lame of	eterv	, 11/18	20c. Loc Ba	ation -	Ore,	own, State Md .	
	21. SIGNATURE OF LINERAL SERVICE LI				22.1	NAME A	ND ADDRE	SS OF FA	CILITY				Elk., Inc. 227	
CERTIFICATION	Sequantially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	B. DUE TO (OF		AB 3	7):	411	ING	Wo	my) S		Interval Between Onsat and Death			
CERTI	that Initiated avants resulting In death) LAST d													
MEDICAL	×				_ 19	PERFORMED? 1 YES 2 NO OF		D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAU:		CE OF DEAT	S L 1			CERTAI	иП					
O	EXAMINER? t XYES 2 NO	HOSPITAL:			OTHER	1:			W. Jimoso Siche					
75	27. MANNER OF DEATH	1 Inpetient 2 E		28b, TIM			JURY AT	ealdence	6 Other (Spe 28d, DESCRIB		I II IDV OC	CHeen		
	1 Netural 5 Pending	(Month, Day,			URY	1 _	ORK?	NO	SUBJE		STAR	SEED		
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF II building, etc	NJURY — AI N (Specify) FARTW	oma, farm,		ory, offic	ce		281. LOCATION City or Tov	(Street a	nd Numbe	or or Rural	MOUTO NAMED)	
COMPLETED	()	BICIAN: To the best of my	knowledge, d	leath occurre										
8	// *	ER: On the beele of even	instion and/or	investigatio	n, in my o	pinion,				place, en				
TO BE	2004. SECONASSISTRE AND TITLE OF CENTIFIE	"Hels	1				1	C.M					(Month, Day, Year) 16,1995	
F	MARIOF GOL	16 JR M	DE BEATH (IT)	1111	Peni	n S	tree	et,	Balti	nor	e, M	lary	land 21201	



	1 -	FOR STATE REGISTR	Α
1	1. D	ECEDENT'S	N

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTI	FICAT	E OF	DEATH	REG	NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEA		VEAD	3. TIME OF D	EATN
		Elwood Gil	bert				NOV 1	13	95	8:31	Рм
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Ve	N nec)	8. BIRTI Count	HPLACE (State o	r Foreign
1	219-18-8596	1∑ M 2 □ F	70 YRS.	MONTHS	DAYS	HOURS MIN.	DEC. 7,		Mary	yland	
	9s. FACILITY NAME (If not institution, give			9b. Cl	TY, TOWN	OR LOCATION OF DI			DUNTY OF	DEATN	
DIRECTOR	St. Elizabeth Nu	rsing Home		Ba	altim	ore		N/.	A		
2	RESIDENCE OF DECEDENT 100. STATE 10b. COUNT	TV.									
E		imore	106. C	IT, IOWN	OR LOCA					10d, INSIDE C	
	10e. STREET AND NUMBER	THOLE			1	Baltimo	re			t TYES 2	
RA	1584 Dellsway Roa	ad			10	f. ZIP CODE	,	10g. C		WHAT COUNTRY	n
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE	D IN ILE ADMED	1 10	100000	2128			USA		
ヹ	1 Never Married 2 🔯 Married	FORCES? 1 Y	ES 2 X NO	"	If yes, sp	CENDENT OF NISPAI ecity Cuben, Mexico	in, Puerto Rican, eti	ry Yee or No c.)	Blac	E — American i k, White, etc.	ndien,
BY	3 Widowed 4 Divorced	IF TES, GIVE WAR OF	TUATES		1 YES	2 NO Specif	y:		Spec	White	
a	15. DECEDENT'S EDU	JCATION	16e. DECEDENT	S USUAL	OCCUPATION	ON	16b, KIND O	F BUSINESS/I	NOUSTRY		
ᇤ	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)				ost of working					
린	9		Busine	ss O	wner		Tave	ern			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA	ME (First, Middle, M.	alden Surname)		
		wood Gilbert	Sr.				Linda O.	Whit	е		
2	19e. INFORMANT'S NAME (Type/Print)					and Number or Rural i	Route Number, City of	or Town, State, .	Zip Code)		
۴ļ	Mary Virginia Gil	Lbert	1584	Dell	sway	Road Ba	altimore	, MD 2	21286		
	20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 X Cremetion 3 ☐ Ren	noval from State	205 PLACE AND DATE	OFDISPO	SITION /No	ame of	DATE 20	. LOCATION	- City of To	own, State	
	4 Donetion 5 Other (Specify)		Metro Cre	mato	ry,	Inc. 11/	14/95 1	Baltim	ore,	MD	
	21. SIGNATURE OF FUNERAL SERVICE E	CENSEE X	· -	22	NAME A	nd address of fa	CILITY	M1	1 .	7	
	George E. Mac	Nabb		20	0 Fr	ederick	Del Pole	Maryla	and,	Inc.	
	23. PART i. Enter the diseeses, or		sed the death. Do	not ente	or the mo	de of dving, suc	h as cardiac or i	Imore,	MD .	Approx	Imete
	shock, or heart failure.	List only one ceuse or	each ilne.		1.1					interval	Between
	iMMEDIATE CAUSE (Final disease or condition	5	movs	(0	11	Cun		+ 1		Onset	end Death
	resulting in death)		S A CONSEQUENCE	DEI:	- 11	Can	reg o	1	ONC	-w	1020
,				** /*							
<u>o</u>	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE	DF):							
CATION	cause. Enter UNDERLYING	•								1	
RTIFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR A	S A CONSEQUENCE	OF):						_	
ERI	resulting in death) LAST	d									
ပ၂	PART II Other significant condition										
CAL	PART II. Other aignificent condition	and contributing to desti	but not resulting	In the t	inderlying		Part I. 24a. WA	S AN AUTOPS RFORMED?	Y 24b	. WERE AUTOPSY AVAILABLE PRI	OR TO
<u> </u>	- Coloran-V	M. M. At	11.00	بر	11	Vermen	1 - YI	ES 2 NO		OF DEATH?	F CAUSE
ME	2/11/4	Land	my	-	1	\ <u>\</u>				1 TES 2	NO
SICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAUSE	-	ES Z	NO	UNCERTAIN	<u> </u>				_
₫	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OE	ОТМ	R:						
2	1 YES 2 NO	1 Inpatient 2 ER/O			1	e 5 🗆 Residence	6 C Other (Specify,)			
PHY	1 Natural 5 Pending	28e. DATE OF INJUR (Month, Day, Yea		WE OF		RK?	28d. DESCRIBE N	OW INJURY O	CCURED		
B	2 Accident Investigation				1	YES 2 NO					
	3 Suicide 6 Could not be 4 Homicide determined	building, stc. (S	IRY — Al home, farm, pecify)	street, fe	ctory, offic	•	28f. LOCATION (S) City or Town, S	treet and Numb State)	per or Rural I	Route Number,	
2 2											
칠Ⅱ		ICIAN: To the best of my kn									
COMPLE	one) 2 MEDICAL EXAMINE	ER: On the beels of examina	tion end/or investigat	on, in my	opinion, d	esth occured at the	Ilme, date end plac	e, end due lo	Iha ceuse(a	e) end manner a	s stated.
- 13	29b. SIGNATURE AND DITLE OF CURTIFIE	R				29c. LICENSE NUN	MBER	29d. D/	ATE SIGNED	(Month, Pay, Ye	B/)
a l	KM	my)				V 3	5621) 10	Nov	11419	195
-	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF	DEATH (ITEM 27) Typ	e, Print)		1	0 0	1			
	K Heally	33	20 Bs	un	دمس	s.A.	. Dal	ナル	11)	2121	7
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE								
	NOV 2 0 1995 A	in attender to	ola M								

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-002

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be neitling at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

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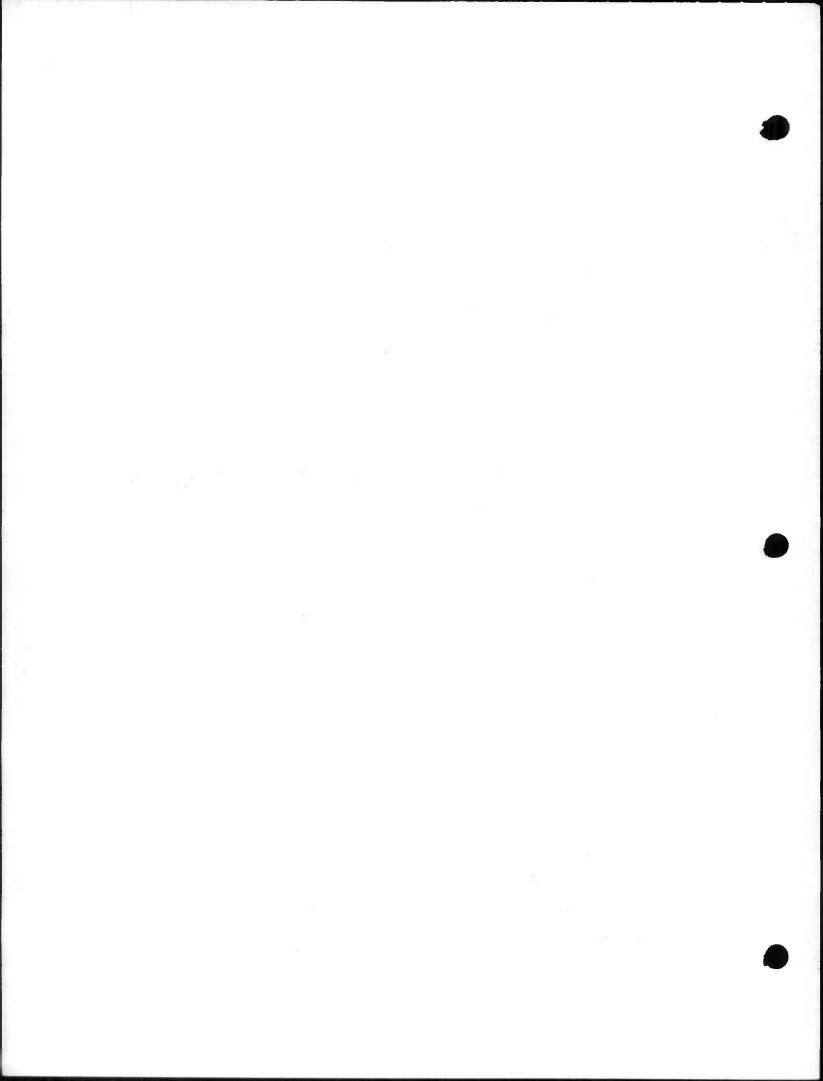
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CERTIF	ICATE	OF	DEATH		REG. NO.				
	DECEDENT'S NAME (First, Middle, Last) Nat	n Gatewood	<u> </u>				2. DAT	e of DEATH	" 19	95ean	3. TIME OF 10:10	DEATH A M
	4. SOCIAL SECURITY NUMBER 215–34–5776	5. SEX 1 M 2 K F	80 YRS.	VTS. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE O				E OF BIRTH	.5	8. BIRTI	HPLACE (SIMO)	or Foreign
TOR	98. FACILITY NAME (If not institution, give standard Road Residence of Decement				town o	OR LOCATION OF	DEATH		9c. cou N/A	INTY OF C	DEATH	
DIRECTOR	10a. STATE 10b. COUNTY Maryland N/A	,	10c. CI	ry, town (OR LOCAT	Baltim	ore				10d. INSIDE	
FUNERAL	2010 Winford Road				101	zip code 212:	39		10g. CIT	USA	WHAT COUNT	RY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced		EVER IN U.S. ARMED YES 2 NO REPRESENTED		It yes, sp	ENDENT OF HISP ecity Cuben, Mex 2 NO Spe	ican, Puert		or No-	Blac	E — American k, White, etc.	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT u	ENT'S USUAL OCCUPATION Ind of work done during most of working NOT use relired.) Stered Nurse/Supervisor Public Hospital System								
BE CON	17. FATHER'S NAME (First, Middle, Last) Edgar Price	2				Allo Processor	Eth	, Middle, Meiden el Safi	fe1			
10	196. INFORMANT'S NAME (Type/Print) Alan Richard Gatewood 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8567 Gradien Dr. Baltimore, MD 21236											
	20a. METHOD OF DISPOSITION 1 Burial 2 & Cremation 3 Removal from State 4 Donation 5 Other (Specify) Donation 5 O											
21. SIGNATURE OF FUNERAL SERVICE LICENSES DAWN F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228						3						
	23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a, DUE TO ((caused the death. Do e on each line. CMMA OR AS A CONSEQUENCE, C				uch aa c	irdiac or respi	iratory a	rrest,	interv	oximate val Between t and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.											
MEDICAL (PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 HO 1 YES 2 HO 1 YES 2 THO								PRIOR TO N DF CAUSE			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
PHYSICIAN:	EXAMINER? 1 YES 2 NO	<u> </u>	ER/Outpetient 3 DOA	_	rsing Hon	ne 5 [\$ Raeldeno						
ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF II (Month, Day		ME OF JURY M	W	JURY AT ORK? YES 2 NO	28d. D	EŞCRIBE HOW I	NJURY O	CCURED		
	3 Suicide 8 Could not be determined		INJURY — At home, lerm, tc. (Specify)	street, tac	tory, offic	20		CATION (Street ty or Town, State)		er or Runal	Route Number,	
COMPLETED	(5.10)		ny knowledge, death occur imination and/or investigat								(e) and manne	r se stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIED	W. 77	Tiller	m	7	29c. LICENSE I	NUMBER 2 7	3	29d. DA	TE SIGNE	17/9:	Year
으	30. NAME AND ADDRESS OF PERSON WH	3, 5601	OF DEATH (ITEM 27) (Typ	e, goige) Ru	iei	Blu	d,	Bau	ut.	Hd	, 21	239
	31. NOVES (MONIMACE)	3 REGISTRAR	IGNATURE									

DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TIME OF DEATH

To to

notified

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be
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COMPLETED

BE

2

3 Suicide

4 Homicide

29a. CERTIFIER

								90		i
1 - STATE REGISTRAR	STATE OF N	MARYLAND / DEPAR CERTIF	TMENT OF	HEALTH	AND		IENE NO.			
1. DECEDENT'S NAME (First, Middle SHIRLEY	e, Last) A NI	N GAR	RRISON	-		2. DATE OF DEA MONTH NOV	TH DAY	1	YEAR 995	3
4. SOCIAL SECURITY NUMBER 219-52-4563	5. SEX 1 M 2 F	6. AGE (In yrs. lest birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS	MIN.	OCT. 30,			B. BIRTHI	
9a. FACILITY NAME (If not institution University Hos	spital		96. CITY, TOWN Baltin		ION OF D	EATH		c. COUN	VITY OF DE	A
RESIDENCE OF DECEDE										_
10a STATE 10b	COUNTY	10- OIT	V TOWN ON LOAD	TION						

1:00 ACE (State or Foreign and тн DIRECTOR IDC. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1411 Division Street 21217 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cube IF YES, GIVE WAR OR DATES Specify: Black B 3℃ Widowed 4 Divorced Specify: COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Metal Finisher Chemical Plant 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ellicott Pope Nellie Oakley Reed B 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Benjamin Garrison 2712 Tivoly Ave. Baltimore, MD 21218 20a. METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Metro Crematory, Inc. 11/17/95 4 Donation 5 Other (Specify) Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cremation Society of Maryland, Inc. Dawn ,F , McDonald 299 Frederick Rd. Baltimore, MD 21228 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition ACQUIRED IMMUNE DEFICINCY SYNDROME resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MALNUTRITION 1 TYES 2 X NO DISSEMINATED MYLOBACTERIUM AVIUM COMPLEX 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 N inpetient 2 - ER/Outpetient 3 - DOA OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 YES 2 YO 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED

27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 1 Natural 5 Pending 2 Accident Investigation

1 YES 2 NO

28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

281, LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year,

REJIDENT PHYSICIA-ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

22.S GREENE ST. BALTIMORE, MD #21201 M.D

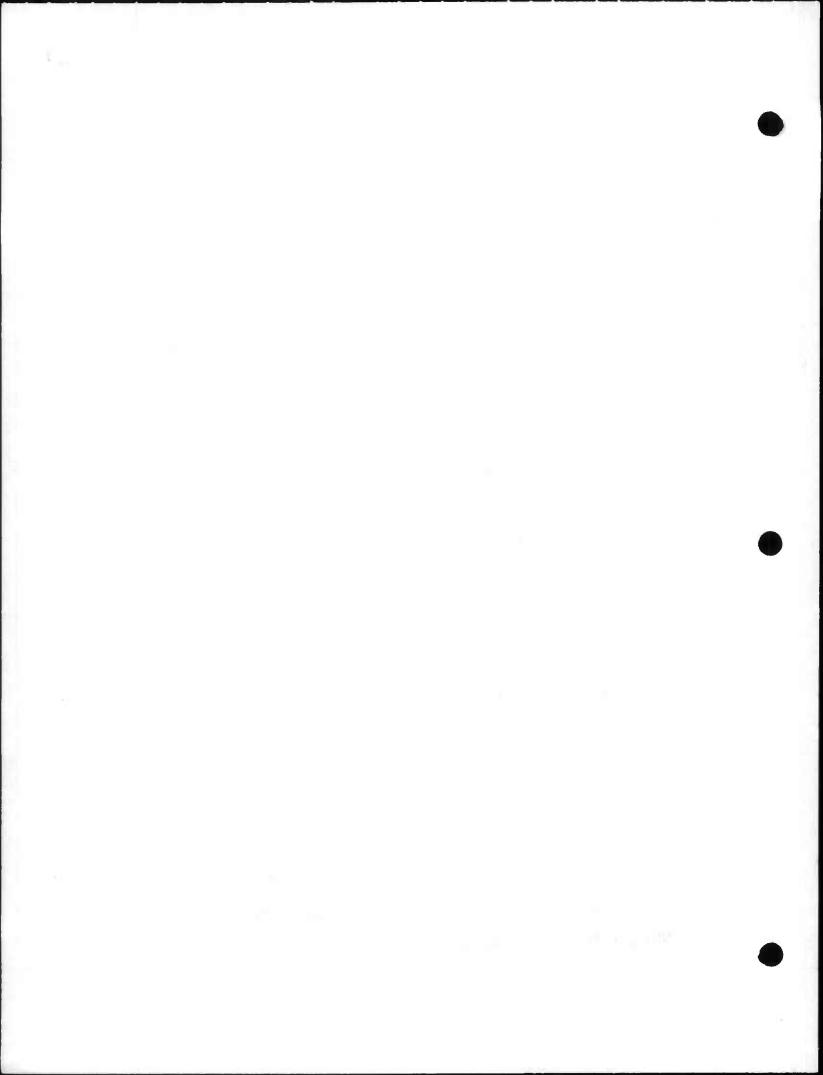
32. REGISTRAR'S

8 Could not be

determined

DHMH-16 Rev 1/89

NOV 13 1995



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float heart. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Proper 1, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

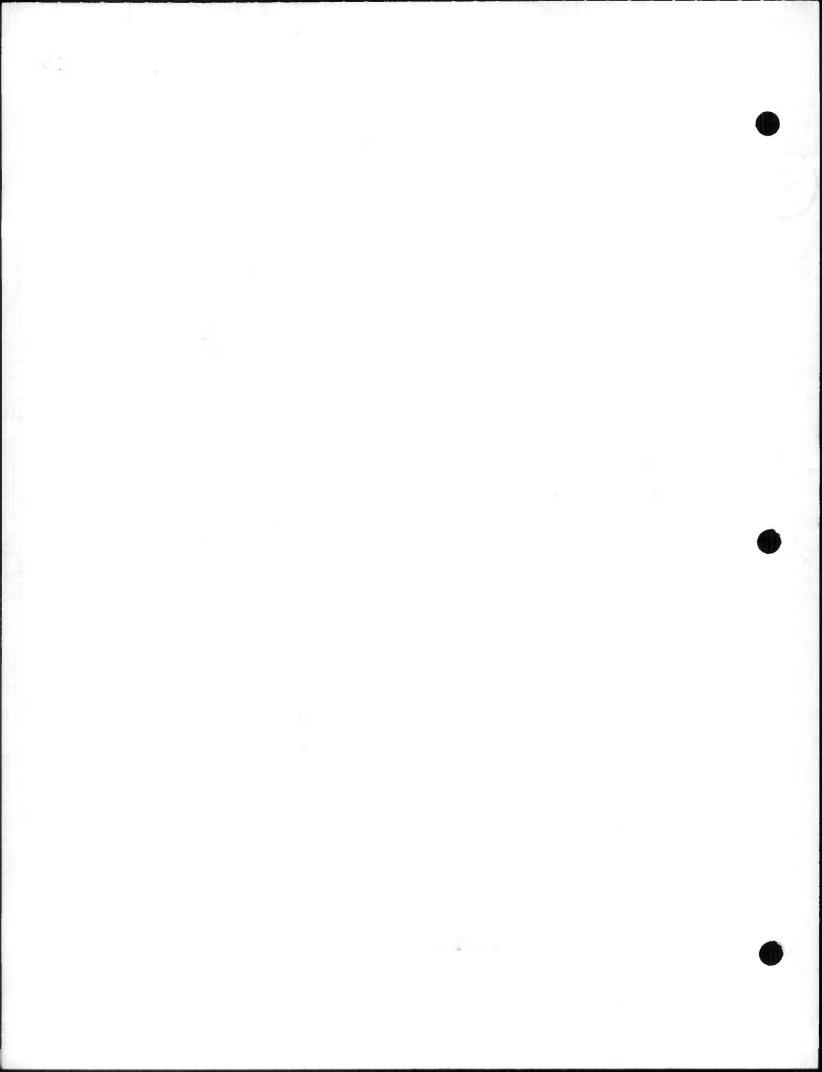
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ATE OF DEATH	REG. NO				
. 8	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH		
1	ROSA	GASQUE		NOV 16	1995	12:30A M		
- 9			F UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign		
- 1	212-18-7583 1 N 2 F	83 YRS.	ONTHE DAYS HOURS MIN.	JULY	3,1912	CAROLINA		
	9a. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN OR LOCATION OF	DEATH	9c. COUNTY OF			
8	4741 IVANHOE AVE.		BALTO. C	ITY	1	N/A		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY							
DIRECTOR		10c. CITY, 1	OWN OR LOCATION	T 6037		10d. INSIDE CITY LIMITS?		
	MARYLAND N/A		BALTO. C	LTY		1X YES 2 NO		
¥			101. ZIP COOE		7-76	WHAT COUNTRY?		
FUNERAL	4741 IVANHOE AVE.		212	~ ~		S.A.		
5	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED	13. WAS DECENOENT OF HISP/ If yes, specify Cuban, Maxic	NIC ORIGIN? (Specify Yes	or No — 14. RA	CE — American Indian, ick, White, etc.		
BY	3 ₩ Wildowed 4 Divorced IF YES, GIVE WAR OR O	ATES A	1 TYES 2 NO Spec		Spi	BLACK		
	15. DECEDENT'S EDUCATION	16e. OECEDENT'S US	IIAL OCCUPATION	145 KINO OE BIL	SINESS/INDUSTRY	DEFICIO		
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of world life. Do NOT use n	done during most of working stred.)	IOD. KING OF BU	SINESS/INDUSTRT			
7	8TH N/A	HOUS	E WIFE	₹ \	A OWN	HOME		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S N	AME (First, Middle, Maiden	Sumama)			
	BONNEY WILLIAMS			A PAIGE				
BE (198. INFOHMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number of Bural Bodin Number City of Trum, State, Zin Code)							
2	EMMA ERVIN	4713	IVANHOE AVE	BALTO, M		212		
		PLACE AND DATE OF			CATION — City or	Town, State		
	4 Doyleton 5 Other (Specify)	netery, cremetory or other RBUTUS M	EM. PK. NOV		Balt			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	0	22. NAME AND ADDRESS OF F	ACILITY				
	(Aliva) D Aria	-1. 12	CALVIN B. S	SCRUGGS F	UNERAL	HOME		
\dashv	23. PART I. Enter the dieaeses, or complications that caused	01/8C	1412 E. PRI	ESTON ST.	BALTO			
	ahock, or haart failure. List only one cause on a	ach ilna.	enter the mode of dying, au	on me cardiac or respi	retory arrest,	Approximate interval Between		
	IMMEDIATE CAUSE (Final disease or condition		<u> </u>			Onset and Death		
1	resulting in death)	TATIC LI	upy Cancer			STERVE		
-		CONSCIONE OF).	l					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	CONSEQUENCE OF):						
S	cause. Enter UNDERLYING							
Ē	that mittated events	CONSEQUENCE OF):						
	resulting in death) LAST			_				
Ö	PART II. Other significant conditions contributing to deeth b	aut not resulting in t	he underlying seven alves in	Seed L. Landon				
EDICAL		at not resulting in t	ne underlying couse given in	Part I. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
				1 _ YES 2	⊠ NO	OF DEATH?		
Σ	DID TODA GOO HOUSE ON THE PARTY OF THE PARTY					1 TES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE O			ИПГ				
PHYSICIAN:	EXAMINER? HOSPITAL:	28. PLACE OF DEATH (THER:					
₹ I	1 YES 2 NO 1 Inpetient 2 ER/Outs 27. MANNER OF DEATH 28s. DATE OF INJURY		□ Nursing Homa 5 Residence					
	1 Netural 5 Pending (Month, Day, Year)	28b. TIME O	WORK?	28d. OEŞCRIBE HOW I	NJURY OCCURED			
B	2 Accident Investigation 3 Suicide Could get by 28s. PLACE OF INJURY	— At home, ferm, stre-	T TES 2 NO	204 0.047/01/05				
	4 Homicide 8 Could not be determined building, etc. (Spec	cify)	or, factory, office	28f. LOCATION (Street a City or Town, State)	ind Number or Rural	Houte Number,		
COMPLETED	29a. CERTIFIER				·			
₹ I	(Check only T pc) CERTIFYING PHYSICIAN: To the best of my know							
8	one) 2 MEDICAL EXAMINER: On the basis of examination	n and/or investigation, i	n my opinion, death occured at the	time, data and place, an	d due to the cause	(a) and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NU	MBER	29d. DATE SIGNE	D (Month, Day, Year)		
# II						, /		
O BE	A MA		103333	0	11111	195		
TO BE	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	nt) i	Colde	11(1)	6/95		
	John Earl Stoker IV MA	3373 A.C	nt) i	Sv. te 655	Baltino	~ 2/2/3		
	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE DE DE DE DE DE DE DE DE DE DE DE DE	3373 A.C	nt) i	Sv. tz 655	Baltino	~ 2/2/3		

DHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68769 BALTIMORE, WARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 inv in the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director ways is smouth for use as the burial-banst permit. Pages 1, 2, 3 st
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: Il Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

pino

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH ELIZABETH VICTOR HALL Vovember 12 3:00A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 🗆 M 2 DAYS HOURS 217-07-3547 1917 December 1 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4 West Lake Avenue Baltimore N/A RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A 1 XYES 2 - NO Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4 West Lake AVenue 21210 **USA** 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE - American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES XX NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16m. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Secretary Telephone Manufacturing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Hugo Victor Mary Elizabeth Brannan BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Howard S. Hall 4 West Lake Avenue Baltimore, Maryland 21210 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State Druld Ridge 11/15 Pikesville, Maryland 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 23. PART I. Entar the disease or complications that caused the dasth. Do not anter tha mode of dying, such as cardiac or respiratory arrest, Approximeta ahock, or haart falls Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition ANCREATIC MONTH reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immedista cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO3 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL OF DEATH? 1 | YES 2 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only b) HOSPITAL 1 YES 2 OTHER: Inpetient 2 - ER/Outpetient 3 - DOA ce 8 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Netural
Accident 5 Pending Investigation м 1 YES 2 NO BY 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. nation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE D-29373 November 13,1995 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eric J. Seitter 10755 Falls Road Suite 200 Lutherville, Maryland 21093 32. REGISTRAR'S SIGNATURE NOV 2 0 1995 Studen Co

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1. OECEOENT'S N	J

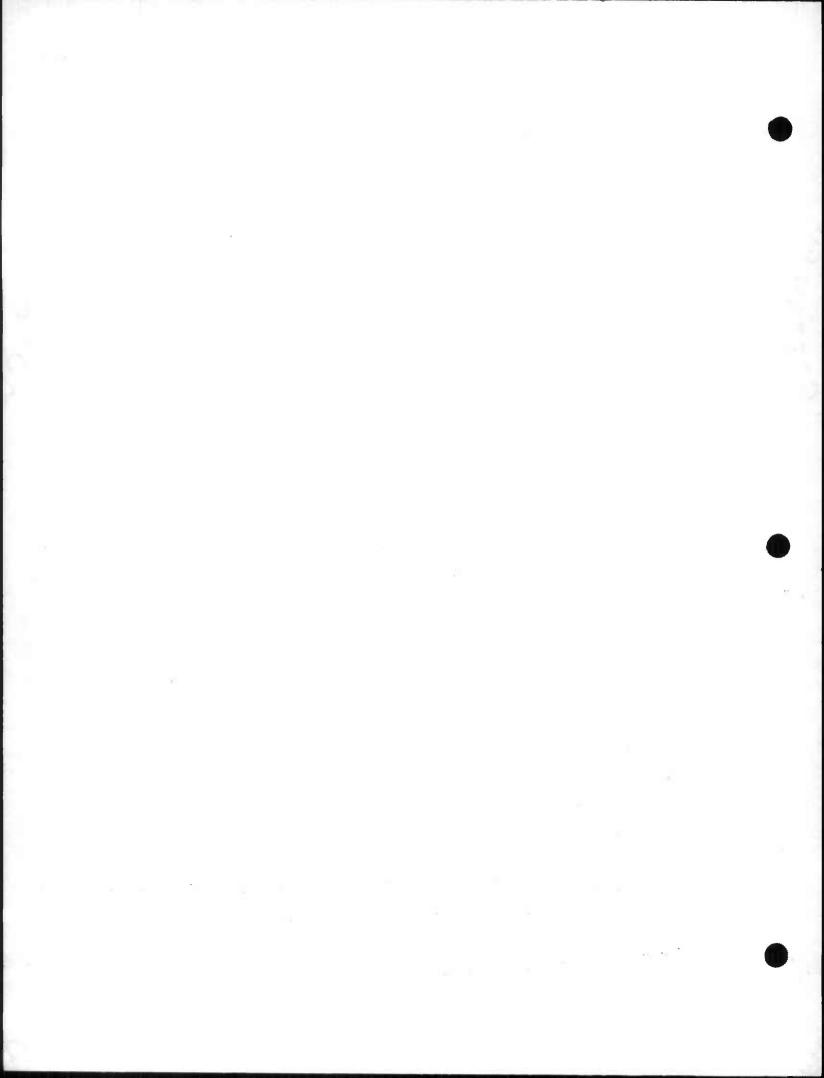
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - REGISTRAR CE	ERTIFIC	CATE OF	DEATH	REG. NO				
	1. OECEOENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH D	AY YEA	3. TIME OF DEATN		
	George Haywood				November		01414 "		
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. les		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yeer)	Co	RTHPLACE (State or Foreign puntry)		
	279-14-3004 1X M 2 □ F 85	YAS.	DATE	min.	July 11,	1910 No	rth Carolina		
	9e. FACILITY NAME (If not institution, give street and number)		•	R LOCATION OF DE	ATH	9c. COUNTY O	F DEATH		
6	Sinai Hospital		Baltimo	re		N/A			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	T 100 CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY		
E	Maryland Baltimore		imore				LIMITS?		
	10e. STREET AND NUMBER	MIL		ZIP CODE		100 CITIZEN (1 YES 2 X NO		
FUNERAL	3413 Old Court Road	21208					l States		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 X YES 2		ED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— 14. RACE Black, tyse, specify Cuben, Mexicen, Puerlo Ricen, etc.)				IACE Americen Indien, Black, White, etc.		
ВУ	IF YES, GIVE WAR OR DATES			2 X NO Specify			White		
	- world war 11	OEDENTIO II	SUAL OCCUPATION	this control of the c	T see kind of hi	SINESS/INDUSTR			
H	(Specify only highest grade completed) (G	ive kind of wo	rk done during mo	st of working	IGB. KIND OF BO	SINESS/INDUSTR	,		
COMPLETED	Elementery/Secondary (0-12) College (1-4 or 5 +)		ant Ope	rator	City G	vernmer	nt		
E CO	17. FATNER'S NAME (First, Middle, Last) Cabell (NMN) Haywood		1/0	18. MOTHER'S NA	ME (First, Middle, Meider	Surname) CAulev			
00	19e. INFORMANT'S NAME (Type/Print)	b. MAILING A	ODRESS (Street a	nd Number or Rural i	Route Number, City or Tov	vn, State, Zip Code)		
5	Martha H. Montgomery	3413	Old Cou	rt Road	Baltimore,	Maryla	and 21208		
		AND DATE OF	DISPOSITION (Ne	me of	OATE 20c. LC	CATION — City of	or Town, State		
	obmotory, or		Cremat			timore,	Maryland		
	21. SIGNATURE OF UNERAL SERVICE LICENSEE			D AODRESS OF FA		*			
	> Town 1. All		ALL CO	ett-Mied	efeld Home	e, Inc.	rland 21212		
	23. PART i. Enter the diseases, or complications that caused the de	eath. Do no					Approximata		
	shock, or heart failure. List only one cause on each line. Interval Batween Onset and Death disease or condition Rocket CAUSE (Final Death Cause Control Cause Control Cause								
Z	Sequentially list conditions b. Sephis Week								
CERTIFICATION	if eny, leading to immediate								
S	CAUSE (Disease or injury Due to (or as a consequence of):								
Ē	thet initiated evente resulting in death) LAST	OULHOL OI)	•				İ		
Ä	d								
YL (PART ii. Other algnificent conditions contributing to deeth but not resulting in the underlying causa given in Part i. 24a. WAS AN AUTOPSY PERFORMED? AMALABLE PRICADA AND AND AND AND AND AND AND AND AND								
DICAL					1 _ YES 2 NO		COMPLETION OF CAUSE DF DEATH?		
ш						^	1 U YES 2 NO		
Y: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	ATH YES	ON D	UNCERTAI	N 🗆		/,		
PHYSICIAN:		CE OF DEATH	(Check only one)						
SIC	EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpatient :		OTHER: 4 - Nursing Nor	e 5 🗆 Reeldence	6 Other (Specify)				
Ή	27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year)	26b. TIME			26d. DESCRIBE HOW	INJURY OCCURE	D		
ВУ Р	1 Natural 5 Pending	l livo	INJURY WORK? M 1 YES 2 NO						
	2 Suicide 28e. PLACE OF INJURY — At h	ome, term, at	ne, term, street, factory, office		281. LOCATION (Street and Number or Rural Route Number,				
TED	4 Homicide determined building, etc. (Specify) City or Town, State)								
)LE	29e. CERTIFIER (Check call) CERTIFYING PHYSICIAN: To the best of my knowledge, d	eath occurred	d at the 11me, date	end plece, end due	to the ceuse(e) end me	enner ee atated.			
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or						use(e) end menner ee stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER		^	29c, LICENSE NU	MBER	29d. DATE SIG	NED (Month, Day, Year)		
BE	Alhumanno Houses	ta 4	_						
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE	EM 27) (Type	Print)	ハンレイリ	1761GC	IN INCOVE	umber 18 1995		
				dere	Balto.	MD 7	21215		
	31. ONE OVER A 1993 Jah 32 DEGISTRAR'S CHAPURE	7.							

al-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21845-00 use as the

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours are death. Page 6 may be estable by 10 and 10 may be attending physician and completely filled in by the funding therefore has been signed by the attending physician and completely filled in by the funding therefore a should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove the most be notified at once. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medited examiner must be notified at once.

DHMH-16 Rev 1/89



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

examiner must be notified at ones. TO BE COMPLETED BY F	IMPORTANT If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMP
al. l examiner must be notified at once.	Decision of the state of the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT II Item 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical experience.
he funeral director, page 5 should be detached for use as the buri	THE PUMPING DIFFCTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burn
ir death. Page 6 may be retained by the hospital or attending phys	TO THE PERFOLL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phys
BALTIMORE, MARYLAND 21215-002	I DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
CE	RTIFICATE	OF DEAT	Ή		REG. NO.

	FOR STATE OF MARYL STATE REGISTRAR		MENT OF HEALTH AND	MENTAL HYGIENI REG. NO.	E							
i	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH 3. TIME OF DEA								
1	WILLIAM F. HORNER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	SR.		MONTH DA	5 2.31 Am							
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE		7. DATE OF BIRTH (Month, Day, Year)		SIRTHPLACE (State or Foreign Country)							
œ	578-07-2752 11XM2 0 F	8 % YRS.	ONTHS DAYS HOURS MIN.	04 23 19	707 W	ash. D.C.						
	9e. FACILITY NAME (If not institution, give street and number)		9c. COUNTY OF DEATH									
DIRECTOR	Mercy Hospital		City	N/A								
EC	10e, STATE 10b. COUNTY	10c. CITY,			10d. INSIDE CITY LIMITS?							
	Md. N/A	Bal	timore			1 TYES 2 NO						
FUNERAL	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?						
E	3016 Second AveBalti	more. Mc	21234		U.S							
5	11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 1 YES		13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic		or No 14.	RACE — American Indian, Black, White, etc.						
ВУ	3 Wildowed 4 Divorced IF YES, GIVE WAR OR I	DATES	1 YES 2 NO Speci	fy:		Specify:						
	15. DECEDENT'S EDUCATION	188. DECEDENT'S US	BUAL OCCUPATION	16b. KIND OF BUS	INESS/INDUST	White						
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+)	(Give kind of wor	rk done during most of working retired.)	1000								
IPL	Grade 12	Factory	Worker	Glenn	L. M	artin						
ON	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S N	AME (First, Middle, Maiden	Surname)							
BEC	George P. F. Horner		Elizal	oeth Babb	ingto	n						
TO B	190. INFORMANT'S NAME (Type/Print)		DDRESS (Street end Number or Rural									
F	William H. Megary, Jr.		Annemessex R									
	1 Buriel 2 Cremetion 3 Removal from State	metery crematory or other	DISPOSITION (Name of er place)			or Town, State						
	4 Donation 5 Other (Specify)	letro Cr	ematory Inc	-11-2D-9	5 Ba.	lto. Md.						
	21. SIGNALURE OF FUNEHAL SERVICE GLUTTER	DELL	3512 Frede		nue							
	G. Truman Schwab		Baltimore,									
	23. PART I. Enter the diseases, or complications that cous- ahock, or heart fellura. List only one cause on		t enter the mode of dying, su	ch aa cardiac or respi	ratory arrest	Approximate interval Between						
	IMMEDIATE CAUSE (Final					Onset and Death						
	disease or condition resulting in death) e. Respiratory Fallure Due To (or as a consequence of):											
	DUE TO VOR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, Due to (or as a consequence of):											
AT	cause. Enter UNDERLYING											
IFIC	that initiated events	A CONSEQUENCE OF):										
ERT	reaulting in deeth) LAST			resulting in deeth) LAST								
	PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDING											
1	PART II. Other aignificent conditions contributing to death	but not resulting in	the underlying cause given I	n Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS						
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	FOR STATE REGISTRAR	, , ,	STATE OF I		ND / DEP	ARTM	ENT OF H	EALTH AND DEATH	MENTA	L HYGIENI REG. NO.	E	, ,	1430	See
	1. DECEDENT'S NAME (First, Middle, Last)				HOLLI	DAY				OF DEATH		3.	TIME OF DEAT	н
	TAMMY				HDAY			NOVEMBER 17, 199				0005	Дм	
	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. D				7. DATE	OF BIRTH		. BIRTNPL/	ACE (State or Fo		
	214-82-6599		1 🗌 M 2 💢 F	30	YR	S. MOH	THS DAYS	HOURS MIN.		th, Day, Year) 25/1965		Country)	band	
	9e. FACILITY NAME (If not in					9b.	CITY, TOWN	OR LOCATION OF I		23/1903	Maryland Doc. COUNTY OF DEATH			_
OR	6400 BLOCK PULASKI HIGHWAY			AY	BALTIMORE CITY N/A									
2	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			100							A MIGURE OUTL			
DIRECTOR	Maryland	N/A				Baltimore							LIMITS?	
AL	10e. STREET AND NUMBER				101. ZIP COOE 10g. CITIZEN OF					EN OF WNA	T COUNTRY?			
FUNERAL	1710 Dundal	k Avo	Ant A2			21222					LIC	LICA		
<u>=</u>	11, MARITAL STATUS	A Ave.	12. WAS DECEDER	IT EVER IN U	J.S. ARMED	5000						American India	in.	
	15/7/Never Merried 2	Merried	FORCES?	YES	2 X NO		If yes, sp	ecify Cuben, Mexic	can, Puerto			Black, W	fhite, etc.	
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0	15. DEC	EDENT'S EDU	CATION	1	16a. DECEDEN	T'S USU	AL OCCUPATE	ON	16	b. KIND OF BUS			JUL 1110	11011
E	(Specify onl	y highest grade			(Give kind life. Do No	f of work of IT use reti	lone during mo red.)	ost of working						
7	10	1-12)	College (1-4 or 5	+)	Home	emak	or				omest	ic		
COMPLETED	17. FATNER'S NAME (First, M	liddle Leet)			HOIN	and v	C.L.	18. MOTHER'S N	AME (Sint			10		
	Claude G.		0.00					10						
BE	190, INFORMANT'S NAME (ear					Eloi		Hollid				_
2	Decay Comments							and Number or Aura						
	Eloise Lock							Ave. Ap	t.A2					
	20s. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State													
	Cremetton 3 Removat from State State Cremetton of the place Cremetton of the place Cremetery, cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place Cremetery or other place Cremetery and the place C													
	21. SIGNAPURE OF FUHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md. 21231													
	Mes	1	-W	-	_								21231	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreat, shock, or hear failure. List only one cause on each line.						Approxima							
	IMMEDIATE CAUSE (Final							Onset and						
	disease or condition reaulting in death)	→		$II \setminus 0$	riti	1) (-	LNIL	Vie	-(
	DUE TO (OR AS A CONSEQUENCE OF):													
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CERTIFICATION	Sequentially list conditions, if any, laading to immediata DUE TO (OR AS A CONSEQUENCE OF):													
8	cause. Enter UNDERLYING CAUSE (Disease or Injury													
Ĕ	that initiated events	iry	DUE TO	(OR AS A C	CONSEQUENC	E OF):								
E	reaulting in death) LAS	T	d											
5			.											
AL	PART il. Othar algnifica	ent condition	ns contributing to	daath but	t not reauit	ng in th	e undarlyln	g cause givan i	n Part i.	24a. WAS AN PERFOR			ERE AUTOPSY FI	
S										YES 2		CC	OMPLETION OF C	
												1/	YES 2 1	NO
PHYSICIAN: MEDIC	DID TOBACCO U	ISE CONT	RIBUTE TO CA	AUSE OF	DEATH	YES [] NO	UNCERTA	IN \square			/	7	
A	25. WAS CASE REFERRED T		1		8. PLACE OF			CittoEitiii						_
길	EXAMINER?		HOSPITAL:			ОТ	HER:							
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ВҰ	2 Accident	trivestigation	////8	175	U	MK	M 1	YES 2 X NO	rec	destr	an al	ruck	- hau	40
		Could not be		OF INJURY - , etc. (Specify	At home, fe	rm, atreet	, fectory, offic	Den .		CATION (Street &	and Number o	r Rural Roul	te Number,	
1	4 Nomicide	determined			STKE	-6			640	00 R/K	- 10	as Ki	IT W	Υ,
ا ڌ	29e. CER UFIER 1 CER	TIFYING PNYS	ICIAN: To the best of	f my knowles	dge, death oc	curred at	the time, date	e end place, end de	us to the c	euse(s) end mer	voer as state	d.		
COMPLETED	const. 1.2		R: On the basis of										nd manner es =	tated.
8	//		1		^	, ***	,							
BE	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year)													
6	1 yau	1	MAR	<u> </u>	W			O.C.M	1.E.		NOV	EMBE	ER 17.	199
-1	THE WANT ATTIT THORSES O	F PERSON WA	O COMPLETED CAL	ISE OF DEAT	TM (ITEM 27)	Time Den	Pl						- 1	

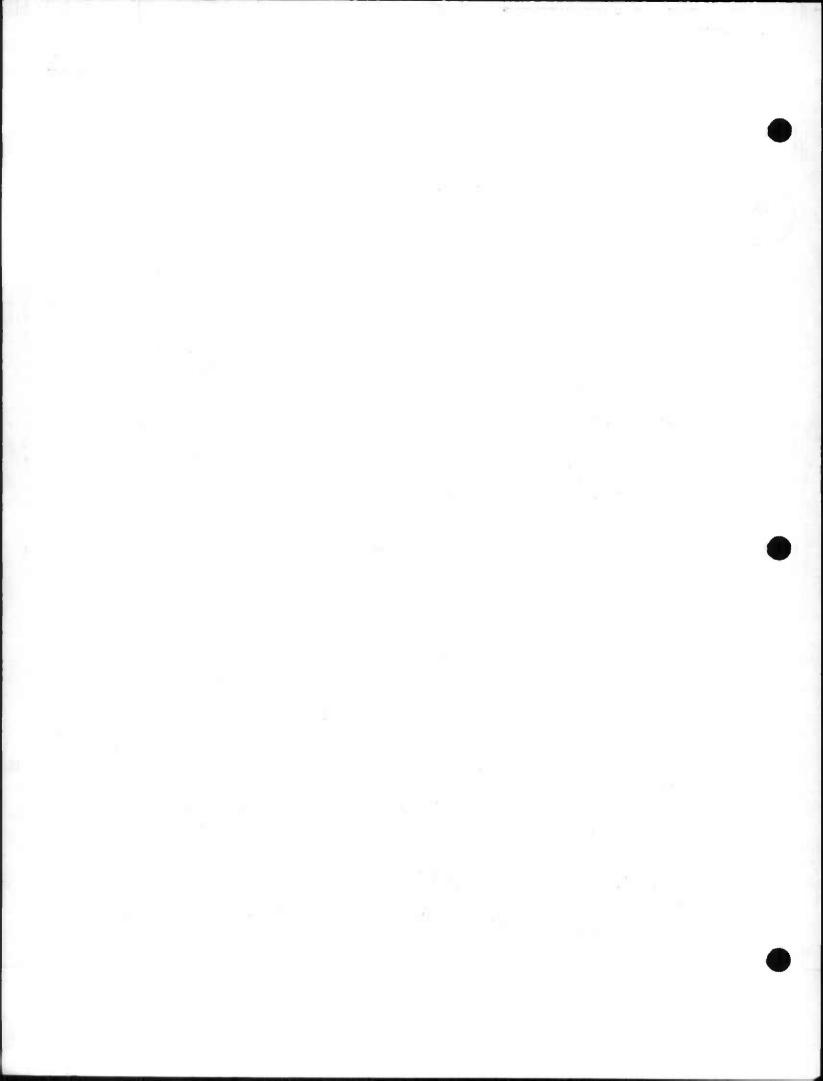
111 Penn Street, Baltimore, Maryland

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit puber filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 6876

BALTIMORE, MARYLAND 21215-0020

31. DATE FILED (Mo



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requires that the death certificate be executed with RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The law

DIRECTOR: After the hours after death was

FUNERAL I TO THE HOSPIT TO THE FUNERA be filed within 7.

is marked,

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It item

DIVISION OF VITAL

BALTIMORE, MARYLAND 21215-0020

2. DATE OF DEATH 3. TIME OF DEATH DAY Elinor Frethy Hyatt YEAR Nov. 18 1995 6:05 aM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Jan. 10, 1921 167-22-3358 74 1 - M 2 - F Pennsylvania 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Dulaney-Towson Health Care Center Towson Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Owings Mills 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 235 Pittston Circle 21117 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MNO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried Specify: White BY 3 Wildowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) COMPL 12 Housewife Homemaker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Edward Austin Frethy Ivy May Gibson BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Lawrence E. Hyatt 13379 Marie Drive, Manassas, Virginia 22111 20s, METHOD OF DISPOSITION
1 A Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Grove Cemetery Nov. 21,1995 New Brighton, Pa. Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 21117 Eckhardt Funeral Chapel Villand 11605 Reisterstown Rd., Owings Mills, Md. 23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition ENDONETRIAL CARCWOMA 76 MOS ETASTANC reaulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO NONE COMPLETION DF CAUSE 1 YES 2 NO OF DEATH? 1 | YES 2 | 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA Ing Home 5 - Residence 6 - Other (Specify) 4 12 No 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) 띪 11 18 036581 15 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 1400 BANDO MO 21218 CHAMLES ST. 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

0 1995

. 9 021 101 5, 5, 7 . 1) en and the second BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atter 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within 24 hours after death. Page 6 may THE FUNERAL DIRECTOR. After this certificate has been signed by the afterding physician and completely filled in by the funeral director, pa he fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funera he filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examili
**D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours **D THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filted in the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or resimple MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the median
*** THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ************************************
THE HDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be 0 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician e fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traus
**O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death c **O THE FUNERAL DIRECTOR: After this certificate has been signed by the attend en field within 72 hours after death with the State Dept. of Health and Mental Hy MPORTANT: If item 28 is marked, or item 23 shows any injury, or
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that THE FUNERAL DIRECTOR: After this certificate has been signed to field within 72 hours after death with the State Dept, of Health a MPORTANT: If item 28 is marked, or item 23 shows any
THE HOSPITAL OR ATTENDING PHYSICIAN: The law THE FUNERAL DIRECTOR: After this certificate has be fied within 72 hours after death with the State Dept. MPORTANT: If item 28 is marked, or item 23
**D THE HOSPITAL OR ATTENDING PHYSIC: **D THE FUNERAL DIRECTOR: After this cer **e filed within 72 hours after death with th **MPORTANT: If Item 28 is marked, e
O THE HDSPITAL OR ATTEND OF THE FUNERAL DIRECTOR: / Re filed within 72 hours after om PORTANT: If Item 28 Is
O THE HOSPITAL O THE FUNERAL Re filed within 72

31. DATE FILED (Month, Day, Year)
NOV 2 0 1995

	FOR 1 - STATE	STATE OF I	MARYLA	ND / DE	EPART	MENT	OF.	HEAL	ГН А	ND N	1ENT/	AL HYGIEN	ر. E	J	04704
	REGISTRAR	<u>.</u>						F DE				REG. NO			
	1. DECEOENT'S NAME (First, Middle, Lest) LAURA JON	NES								N	MON	MBER	1 6,1	995	3. TIME OF DEATH 5:15 Pm
ì	4. SOCIAL SECURITY NUMBER 220-07-4482	5. SEX	6. AGE (In	yrs. last birti		IF UNDER	1 YEAF		DER 24	\rightarrow	7 DAT	E OF BIRTH			HPLACE (State or Foreign
ij					rrs.			-				C. 5,	189	9	NC
œ	9a. FACILITY NAME (if not institution, give street and number)						OR LOC			ATH			INTY OF		
57	SUMMIT NURSING HOME				-CP	ATC	NSV	IL	LE			BAL	TIM	ORE	
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND BALT	IMORE				TIM									10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER						_	101. ZIP C	ODE				10a CI7	17EN 0E	1 X YES 2 □ NO WHAT COUNTRY?
FUNERAL	8 WALDEN LAUR	EL COUR	Т					212		7				TEL	
S	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN	U.S. ARMED)	13.	WAS D				C ORIG	IN? (Specify Yar			
BY F	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE V	YES YAR OR DAT	2 XNO				specify C				Rican, etc.)		Blac	E — American Indian, ck, White, stc.
	5 Widowed 4 □ Divorced														BLACK
Ē	1s. DECEDENT'S EDUC (Specify only highest grade			16a. DECEDI (Give kir	ind of wo	ork done o	during i	TION most of wo	orking		16	b. KIND OF BU	SINESS/IN	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5	+)		NOT use	ICI.	A 3.T					COSM	ידיים	70	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	2		DEA	LUI.	ICI.	AIN	40.44	OTHE	200 1141	5 (5)			<u> </u>	
	JOHN MINCEY									VIA		Middle, Maiden	Sumame)		
BE	19a. INFORMANT'S NAME (Type/Print)		-	19b. MA	AILING A	DORESS	(Stree	_			_	mber, City or Tow	o Ctoto 7	o Codel	
2	RHONDA JACKSON														21207
	20g, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of														
	4 Donetton 5 Other (Specify) ARBUTUS MEM. PK. 11-21-ARBUTUS, MD														
	21. SIGNATULE OF FUNERAL SERVICE LIC	ENSEE	-					AND ADD	RESS	OF FAC	ILITY	270	FPF	DHI	LTON PASS
	of alim L.	Ma	lin	-6				IN				IAMS]	F.S.	В	ALTO., MD
	23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fallura. List only one cause on each line. Approximate interval Between														
	IMMEDIATE CAUSE (Final											-			Onset and Death
							lo	n	a	enic	LLI	it		_	months
	DUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):														
YAT	if any, leading to immediate cause. Enter UNDERLYING														j
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A C	CONSEQUEN	ICE OF):										
	resulting in death) LAST														
CC	PART II. Other aignificant conditions	contribution to	death but	t ant mand		Abo	el a mir d					T			
CAI	Rypertin		Geath but	t Hot readi	ung m	the un	deriyi	ng caus	e give	en in P	art I.	PERFOR	MED?	248	AMILABLE PRIOR TO
	- CONDECTOR	((() ()									_	1 TES 2	KNO		OF DEATH?
PHYSICIAN: MEDICA	DID TOBACCO USE CONTR	IDLITE TO CA	LICE OF	DEATH	VEC		10.	7	ICET	TA IN I	701				1 TES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	IBUIE IO CA		B. PLACE OF					NCER	RTAIN	A				L.
200	EXAMINER?	HOSPITAL:				OTHER	l:			=: =:					
H	27. MANNER OF DEATH	28a. OATE OF	INJURY		b. TIME	OF		JURY AT	_	9		er (Specify)	NJURY OC	CUREO	
ВУ Р	1 Natural 5 Pending	(Month, D	ay, Year)		INJUI	RY M		YES 2	E N	- 1	28d. DEȘCRIBE HOW INJURY OCCUREO				
	2' Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY -	- At home, fi	ferm, str	ast, facto	ory, off	lce			28f. LOCATION (Street and Number or Rural Route Number,			Route Number,	
III II	4 Homicide datermined	Conting,	atta (apacity	"							City	or Town, State)			
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of	my knowled	dge, death o	ccurred	at the ti	me, da	te end ple	oca, an	nd due to	o the ca	ouse(s) end mar	ner se ste	led.	
ĕ															a) and manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	1		1					ICENS	E NUME	BER				(Month, Day, Year)
3 BE	Mare	& an	4/	AN				D	-1	+0	SZ				.17,1995
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEAT	H (ITEM 27)	(Type, P	Print)	7	ren	JU	E	Su	TE			F
	DR OCHANE		> 3	CALC	~	-1-	24	17	m	DRF		mp	212	79	

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

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1995

3. TIME OF DEATH

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REG. NO.

2. DATE OF DEATH

November 17

FOR STATE REGISTRAR

Adam

1. DECEDENT'S NAME (First, Middle, Last)

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July 9,1921 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 74 Maryland 213-18-3711 XX M 2 - F be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9c. COUNTY OF DEATH 9b. CITY. TOWN OR LOCATION OF DEATH Franklin Square Hospital Rossville DIRECTOR Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Maryland Baltimore 10d. INSIDE CITY Baltimore County 1 YES 2XX NO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21236 4565 Ridge Rd. USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, atc. If yee, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? XXX YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried Specify: BY 3 Widowed 4 Divorced White WW 11 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life, Do NOT use retired. Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) Construction Industry Truck Driver once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frank Klein Wilhelmenia Schissler at BE page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 4565 Ridge Rd. Baltimore, Maryland 21236 Mrs. Marie C. Klein pe 20a, METHOD OF DISPOSITION
1 Description | Method of Disposition | Burlai | 2 | Cremation | 3 | Removal from State OATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must funeral director, p Str. Joseph CM. Cemetery 11-20-95 Fullerton, Maryland 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
Lassahn Funeral Home examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jassahn Heather 7401 Belair Rd. Baltimore, Md. 21236 and completely filled in by the bunal, cremation, or removal. medicai 23. PART i. Enter the dieeeses, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ehock, or haert fellure. List only one cause on sech line. Interval Between Onaat end Death IMMEDIATE CAUSE (Finel the disease or condition resulting in death) 2 years . Metastatic colon cancer event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): 0 If any, leading to immediate cause. Enter UNDERLYING certificate has been signed by the attending physician the State Dept. of Health and Mental Hygiene prior to CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events 0 Injury. PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24e. WAS AN AUTOPSY MEDICAL PERFORMEO? WAIL ARLE PRIOR TO Liver failure COMPLETION DF CAUSE OF DEATH? any 1 YES 2 NO shows a Renal failure 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO XX UNCERTAIN PHYSICIAN: 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item **EXAMINER?** HOSPITAL OTHER: 1 YES 2 NO 1 √ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF OEATH 28d. DESCRIBE HOW INJURY OCCURED with t marked, 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO OIRECTOR: After the hours after death vitem 28 is mark ВУ 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 26e. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 3 Sulcide COMPLETED 8 Could not be 4 Homicide OR 29e. CERTIFIER
(Check only one)

One)

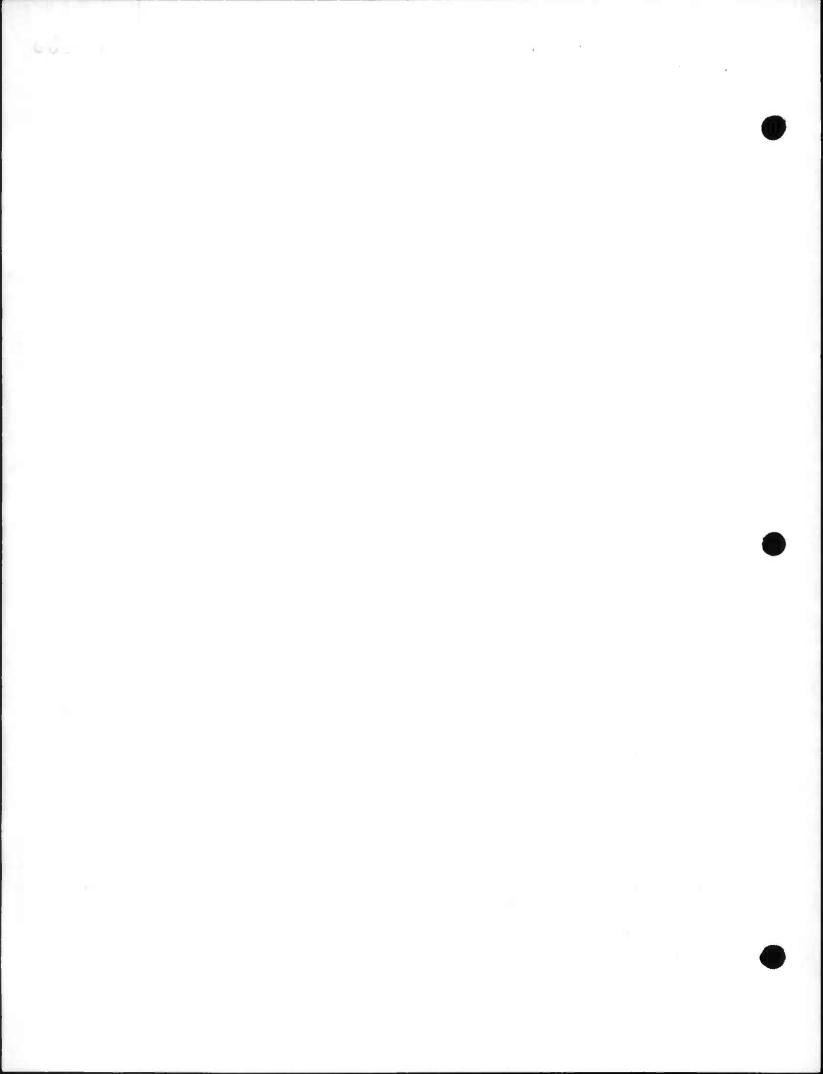
MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) and manner as stated. TO THE HOSPITAL O
TO THE FUNERAL O
be filed within 72 ho
IMPORTANT: If Its 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 品 NOVEMBER 17, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Francis Khoo 9000 Franklin Square Drive Baltimore, Maryland 21237 Jali 32 Miliatras Candida

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours af
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		1 - FOR STATE REGISTRAR	STATE O	F MARYL	AND / DEPAR CERTIF		HEALTH A		TAL HYGIEN			
		1. DECEDENT'S NAME (First, Mid Betty Jar	ne Kight					2. DA	NTH OF DEATH	^ 1995	3. T	IME OF DEATH):00 A M
P		4. SOCIAL SECURITY NUMBER 233-50-2989		F 61	(In yrs. last birthday) YRS.	IF UNDER 1 YEA	'S HOURS	MIN. NO	TE OF BIRTH lorth, Day, (bar)	L933 V	Country) Vest	E (State or Foreign Virginia
2, 3 should	CTOR	9a. FACILITY NAME (If not instituted as 1501 Gung	owder Rd			1	n on Location	OF DEATH		Balt		
physician. burial-transit permit. Pages 1, 2,	DIREC	10a. STATE 108	Baltimore	=		inebo			-		10d.	INSIDE CITY LIMITS? YES 2 NO
ı. ınsit permi	FUNERAL	100. STREET AND NUMBER 21501 Gung	powder Rd	•			101. ZIP CODE 2108	38		U.S.	OF WHAT	
attending physician. se as the burial-tran	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 VES 2 FORCES? 1 FYES, GIVE WAR OR DATES			2 NO	If yes	DECENDENT OF I specify Cuban, YES 2 NO	Mexican, Pue	IGIN? (Specify Yerto Rican, etc.)	s or No- 14	. RACE — A Black, Wh Specify:	merican Indian, Ita, etc. White
al or for u	APLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			16a. DECEDENT'S (Give kind of life. Do NOT u	work done during se retired.)			Own H		TRY	
be der	E COMPL	17. FATHER'S NAME (First, Middle, John King		burg			1-1 4.7		itzmil			
be retained to ge 5 should be notified	TO B	19a. INFORMANT'S NAME (Type/T Charles E.	Print)				et and Number or	Rural Route N	lumber, City or Tow Lineb	rn, State, Zip Co		088
6 may tor, pa		20a, METHOD OF DISPOSITION 1 M Burlel 2 Cremation : 4 Donation 5 Other (Spe			b. PLACE AND DATE			Nov.	S Mi	cation - cin		itata
9 7 9		22. NAME AND ADDRESS OF FACILITY J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349										
ted within 24 hours after d completely filled in by the fial, cremation, or removal.		23. PART i. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each ilns. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):										
th certificate be executed tending physician and con if Hygiene prior to burial, or other traumatic er	CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):										
v requires that been signed by tr. of Health and shows any	MEDICAL	PART II. Other algnificant o	conditiona contributin	g to death t	but not resulting	in the underl	ying cause giv	en in Part I	24a. WAS AN PERFOI 1 — YES	RMED?	CON OF E	E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE DEATH? YES 2 NO
SICIAN: The law certificate has be the State Dept.	SICIAN	25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 NO	HOSPITAL		patient 3 🗆 DOA	OTHER:	PLACE OF OEA					
NG PHYSICIA fler this certif eath with the marked, or	У РНУ	27. MANNER OF OEATH 1 Partial 5 Pend	28a. OAT	E OF INJURY oth, Day, Year)	28b, TIR	IE OF 28c.	INJURY AT WORK?	28d.	OESCRIBE HOW	NJURY OCCUP	RED	
OR ATTENDING F DIRECTOR: After 1 hours after death item 28 is mar	TED B	3 Suicide 6 Coul	28s. PLA	CE OF INJURY ding, etc. (Spe	Y — At home, ferm, icify)	atreet, factory, o	office	281. 1	LOCATION (Street City or Town, State)	and Number or	Rural Route	Number,
AL OR AL DIR 2 hour	COMPLE	one) 2 MEOICAL	NG PHYSICIAN: To the best									menner as stated.
TO THE HOSPIT TO THE FUNER DE filed within 7 IMPORTANT:	TO BE	29b. SIGNATUME AND TITLE OF	CERTIFIER				29c. LICENS	E NUMBER	475	29d. DATE S	IGNED (Mor	M, Dey, Year)
	1	30. NAME AND ACCRESS OF PER	rse 4	Dein	er 9	5 (2	Ha	(Fo)	-QR	d	Bal	to. ml
		NOV 2 0 1995		STRAR'S SIGN								



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DISION OF VIEW PEOPLES, F.O. DON ON	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writhin 29 mouns aren ureaus, rage to make a should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

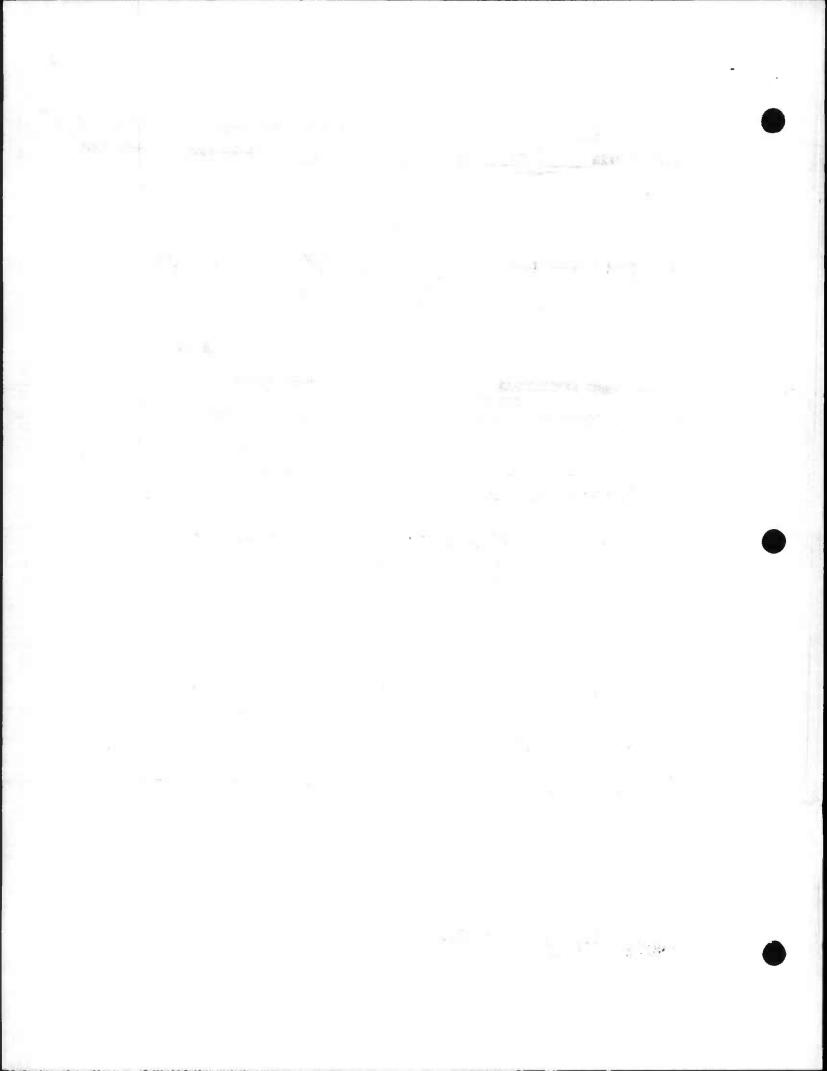
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FilmG, 729, item #1, 11/20/95,cyw, per f.h.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFIC			MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Las	DOROTHY NAO				2. DATE OF DEATH DA	19	year 0840 A.m.	
	4. SOCIAL SECURITY NUMBER 213-18-9604	5. SEX 6. AGE (In		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Ballimore, Md.	
TOR	90. FACILITY NAME (If not institution, give the property of th	SQ. WOSI	O MAL!	BALT	OR LOCATION OF DE	_	9c. COUNT	Y OF DEATH HLTIMORE	
DIRECTOR	10e. STATE 10b. COU	Raltimore Co.	10c. CITY, T	OWN OR LOCA Baltir				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	10e. STREET AND NUMBER				r. ZIP CODE			EN OF WHAT COUNTRY?	
FUNERAL	5 Amys Way Court	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	21234	IIC ORIGIN? (Specify Yee		.S.A.	
ВУ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, s	pecify Cuben, Mexice S 2 X NO Specify	n, Puerto Rican, etc.)		Specify: White	
TED	15. DECEDENT'S E (Specify only highest gra	ade completed)	16a. DECEDENT'S US (Give kind of work life. Do NOT use re	done during m	ON ost of working	16b. KIND OF BUS	INESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Meat Pack	ker			ery S	tore	
BE CO	17. FATHER'S NAME (First, Middle, Last) Roland C. Kelloc	jg				ta Dresch	Surname)		
10	190. INFORMANT'S NAME (Type/Print) Mrs. Patricia J.	. Zimmerman	5 Amys			Route Number, City or Town timore, Mar			
	20e. METHOD OF DISPOSITION 1 Burlel 2 K Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State 20b.	PLACE AND DATE OF C			20,95 Tows		ty or Town, State ryland	
	21. SIGNATURE OF FUNERAL SERVICE	Jeffrey L.	Gair	Leon	ard J. Ru		more	Maryland 21214	
CERTIFICATION	23. PARTM. Enter the disease, a shock, or heart failur immediate cause (Final disease or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST	a. IN TRAC B. DUE TO (OR AS A OR CO.)	EREY	RAL	HEW	ORRHA ORRHA HICUM	at-	Interval Between Onset and Death	
PHYSICIAN: MEDICAL CE	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO								
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEATH		UNCERTAI				
HYSI	1 PES 2 NO	Inpetient 2 ER/Outpe			me 5 🗆 Reeldence	8 DOther (Specify)	VIURY OCCI	IRED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	Y W	ORK? YES 2 NO				
ED	3 Suicide 8 Could not 4 Homicide determined		At home, ferm, stre	et, fectory, offi	ce	281. LOCATION (Street of City or Town, State)	and Number o	or Rural Route Number,	
COMPLET	CONSTRUCTION OF THE CONTROL OF THE C	YSICIAN: To the best of my knowle							
TO BE C	Steven	Muson ?	M.D.		D 72	by7	29d. DATE	SIGNED (Mooth, Day, Year)	
_	31. DATE FILED (Mary) Care, Walt)	WHO COMPLETED CAUSE OF DEA	TIDE	RANG	LIN SG	DR, BA	MM	OR,MO 2123)	
	NOV 2 0 1	995 July 20 W	ar landell			(1	

10 THE HUSPITAL OR ALLENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transi		
d by the hos	d be detache		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
be retained	ige 5 shoul		e notifie
Page 6 may	director, pa		er must b
fler death.	the funeral	oval.	al examin
E SUDON 52	filled in by	tion, or rem	the medic
cuted within	1 completely	urial, cremat	ic event,
are be exec	hysician and	prior to bu	ir traumat
leath certific	attending p	ntal Hygiene	ry, or othe
s that the c	ned by the	alth and Me	any inju
law require	as been sig	Dept. of Hea	23 shows
SICIAN: The	certificate h	the State [, or item
NUING PHYS	: After this	r death with	is marked
L OH ALLER	DIRECTOR	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	item 28
E HOSPIIA	E FUNERAL	d within 72	RTANT: II
10 14	TO TH	be file	IMPO

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			ENTAL HYGIEN				
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	PHILIP F. LEBKUEC	HER		Lebku	Lecher	November		95 /2/8 P M		
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	, ,	BIRTHPLACE (State or Foreign		
DIRECTOR	222-24-0126 9a. FACILITY NAME (If not institution, give str	1 XM 2 F 89	YRS.	ONTHS DAYS	OR LOCATION OF DEA	6-24-1906		Country YORK Y OF DEATH		
	PENINSULA REGIO		1		ISBURY	in .		ICOMICO		
딦	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CITY	TOWN OR LOCA	TION			10d. INSIDE CITY		
	DELAWARE KENT		DOVE				LIMITS?			
FUNERAL	10e. STREET AND NUMBER				ZIP CODE			N OF WHAT COUNTRY?		
NE	2915 DYKE BRANCH			19	9901		USA			
FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO		ENDENT OF HISPANIC ecify Cuban, Maxican,	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-	I. RACE — American Indian, Black, White, etc.		
В	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1 TYES	2 XNO Specify:	. ,		Specify: WHITE		
	15. DECEDENT'S EOUC	ATION	16a. DECEDENT'S U	SUAL OCCUPATH	ON .	16b. KIND OF BUS	SINESS/INDUS			
H	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of worlife. Do NOT use	rk done during mo retired.)	st of working					
릴	8	0	FARMER			FARMING				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAM	E (First, Middle, Maiden	Sumame)			
BE	JOHN ADAMS LEBKU				ANNA KLE	IN				
2	19e. INFORMANT'S NAME (Type/Print)	(NIFE)				ute Number, City or Tow				
-1	HELEN MOSS FORESTE	R LEBKUECHER	2915 I	YKE BR.	ANCH ROAD	, DOVER,	DEL. 1	9901		
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State come	PLACE AND DATE OF elery, cremetory or othe LLYWOOD (r nincol	me of Y 11-16-1	1		y or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAME A	D ADDRESS OF FACI	LITY		,		
	Thomas R.	1				HOME INC				
	23. PART I. Enter the diseases, or co	emplications that caused	the death. Do not	112 LO	de of dying such	T, DOVER,	DEL.	t, Approximate		
	anock, or haert failure. L	ist only one cause on ea	ch ilne.			as carero or roop.	tatory arros	Interval Between Onset and Daath		
	resulting in death) e. MG-G/1/4 FCGA: FGI/WE YEARS DUE TO OR AS A CONSEQUENCE OF):									
z	disease or condition resulting in death) o. Concret ive Items Failure Years DUE TO OR AS A CONSEQUENCE OF: Sequentially list conditions, b. Renal Failure 3-4days									
일	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
CA	CAUSE (Disease or injury									
E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	d									
AL 0	PART II. Other significent conditions	contributing to death bu	t not resulting in	the underlying	g ceuse given in P	ort I. 24e. WAS AN		24b. WERE AUTOPSY FINDINGS		
						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
AED					-	- 110123	× NO	OF DEATH?		
7	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES		UNCERTAIN	īsk		1 725 2 100		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
Sic	EXAMINER?	HOSPITAL:		THER: Nursing Hom	e 5 Realdence 6	Other (Specify)				
E	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME (URY AT :	28d. DESCRIBE HOW II	NJURY OCCUP	RED		
BY	1 Natural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ES 2 NO					
1.00	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, etc. (Specif	- At home, farm, stre	et, factory, office		281. LOCATION (Street a	nd Number or	Rurel Route Number,		
	4 Homicide detarmined									
COMPLETED		IAN: To the beat of my knowle								
Ö	2 MEDICAL EXAMINER	On the besis of examination	end/or inveatigation,	in my opinion, d	eath occured at the ti	me, date and place, an	d due to the c	sause(e) and manner ae stated.		
BE	286. SIGNATURE AND TITLE OF CENTIFIER	0.			29c, LICENSE NUMB		29d. DATE S	IGNED (Month, Day, Year)		
10 E	that	1 BO			D3476	8	· //	112/95		
	36. HAME AND ADDITES OF PERSON WHO		-				/			
	Dr. Jeffrey Wi	cland-560	Rivers	ide Dr	BLOI S	alisbury	md.	21841		
	NOV 9 0 1995	32 REGISTRAR'S CHA								



Pages 1, 2, 3 should

permit.

the horizonal or attending physician.

uld be detached

director,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

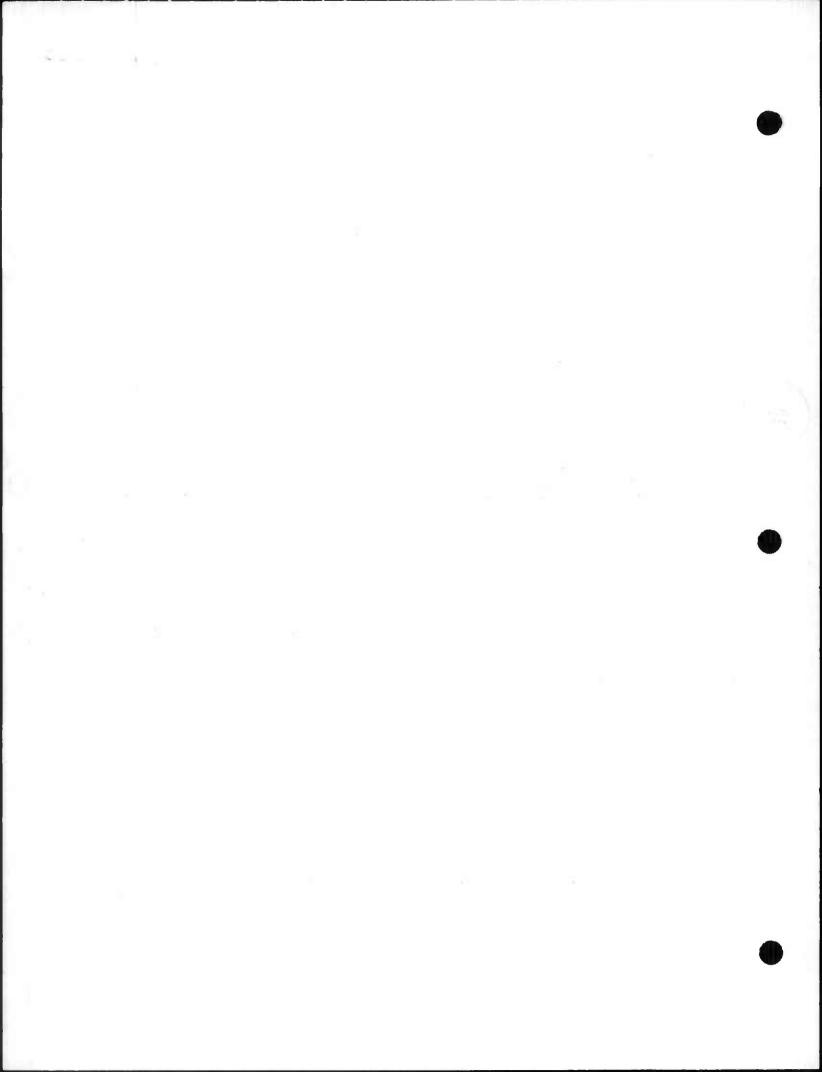
DR. KENDALL FAULKNER 2300 DULA

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DISION OF THAL ALCOADS, F.O. DOA 80/60	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. P	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral 2 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH DORIS McKELDIN LOOMIS November 995 2:25 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 10/7/17 IF UNDER 1 YEAR | IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 1 M 2 TF 78 DAYS NOURS MIN. VPS 213-10-9005 Maryland 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Towson Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Parkville 1 YES 2 X NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 8443 Water Oak Road 21234 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: B 3 🗍 Widowed 4 🗍 Divorced White 18. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only higheat grade completed) (Give kind of work done life. Do NOT use retired.) Ш Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th Grade Manager Insurance Co. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Unknown McKeldin Magdeline BE Unknown 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Arthur Loomis 8443 Water Oak Road Baltimore, MD must be 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 ☐ Donation 8 ☐ Other (Specify) _ Moreland Memorial Park 11/13/95 Hillendale, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LA 22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286 medical 22 PADT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line, Interval Between IMMEDIATE CAUSE (Finel Onset end Deeth the disease or condition OLONCANCER 14mos reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentielly list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST ö Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY METASTASES shows any 1 - YES 2 XNO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TES 2 NO 1 Inpetiant 2 ER/Outpetiant 3 DOA 10 4 - Nursing Home 8 - Realdence 8 Tother (Specify) HOSPICE 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked. 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28a. PLACE OF INJURY — At home, term, streat, lactory, office building, etc. (Specify) 3 Suicide .69 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be Item 28 4 Homicide determined 29a. CERTIFIER 1 Chack note 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL TO THE FUNERAL (be filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER B 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Endale taultueins 25643 9/95 9

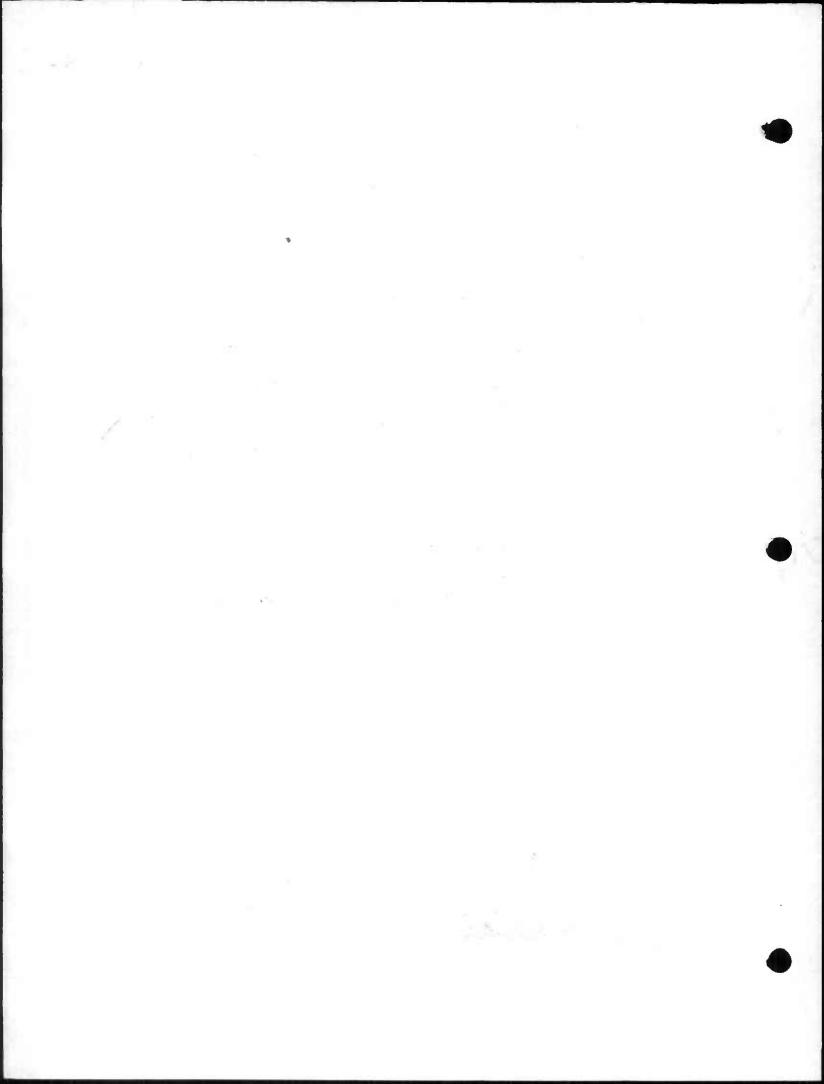
2300 DULANEY VALLEY RD.

TOWSON, MD 21204



concres on exercinist also has been an advert and foods he meanted us. A house star death Done & may be cooked as otherwise he started as the branched as otherwise.	UTH TUSH IAL UN ALIENTING FITTOLICIAN: THE BAT REQUIRED THAT UNDER CONTINUE AND ALIENTIAN AND ALIENT	O THE FUNEFAL DIRECTOR: AffeCTINS CENTICATED AS DEED SIGNED BY THE ARENDING PRESSION OF AREA TO THE CONTINUES OF STRUCTURE AND THE CONTINUES OF STRUCTURE A	be filed within 72 hours after death with the State Dept. of Health and Merital Physiene prior to Durial, cremation, or removal.	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
and Tries and Contract Offi	IO THE MUSHING OR	TO THE FUNERAL DIR.	be filed within 72 hour	IMPORTANT: If iten	

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEN		0 10 10		
	1. DECEDENT'S NAME (First, Middle, Last) LERDY E.	MCCUR	LEX			2. DATE OF DEATH	YEAR 95			
	4. SOCIAL SECURITY NUMBÉR 219-12-7344	1) M 2 F		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JUNE 15, 1	Co	RTHPLACE (State or Foreign untry) laryland		
OR	9a. FACILITY NAME (If not institution, give str Bon Secours Hos			эь ситу, тоwн о Baltimo	F DEATH					
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Md.	N/A	· ·	TOWN OR LOCAT	ON		10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 217 S. Bentalou	St.		101.	ZIP CODE 21223	3	-01	F WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN FORCES? 1 VYES IF YES, GIVE WAR OR DA	U.S. ARMED 2 NO TES	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 N NO Specify: 1 Specify:						
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	ille. Do NOT use	ork done during mo: retired.)	N It of working	16b. KINO OF BU					
COMP	8 17. FATHER'S NAME (First, Middle, Lest) Leroy E. McCur	N/A ley, Sr.	Carpen	Johns Hopkins Univers: 16. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Scharf						
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (Street a		Route Number, City or Tow	n, State, Zip Code))		
임	Margaret Marie M	cCurley	217 S	. Benta	lou St.,	Balto., M	d. 212	23		
	20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town, State 1. (XBurlet 2 Cremation 3 Removal from State Baltimore National Cem. 1. Baltimore Md.									
22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Ell EGOS Main Of Eller Main Charles and Address of Facility								4007		
CERTIFICATION	23. PARTY. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory errest, ehock, or heert failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Active Myocardial Infarction Due to (or as a consequence of): a. Due to (or as a consequence of): a. Due to (or as a consequence of): CAUSE (Disease or injury that initieted events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
PHYSICIAN: MEDICAL CERT	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. PERFORMED? 1 YES 2 100 PIDIT TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:						
	1 YES 2 NO 27. MANNER OF DEATH 1 Postural 5 Pending	1 Inpetient 2 DER/Outp 28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 26c, INJ	URY AT RK?	6 Other (Specify) 26d. DESCRIBE HOW	INJURY OCCURE			
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Spec	— At home, farm, at		ES 2 NO	281, LOCATION (Street City or Town, State)		ral Route Number,		
COMPLETED	opel	CIAN: To the best of my knowl						se(e) end manner as stated.		
TO BE CO	296. SIGNATURE AND TITLE OF CERTIFIER W-8 29c. LICENSE NUMBER 29d. DATE SIGNED (Morith, Day, Your) \$\int \text{303} \text{303} \text{55}\$ \$\int \text{11/9/95}\$ 30. NAMETAND ADDRESS OF PERSON, WHO COMPLETED CASSE OF DEATH (ITEM 27) (Type, Right) ROSETA R. CRUZ. BON SECOURS FOSPITAL									
	ROSITA R. CRUZ BON SECOURS HOSPITAL									
	NOV 2 0 1995 John	31. DATE FILED (Month Day Year) Julia 22, SEGISTI S. SCHATURE								

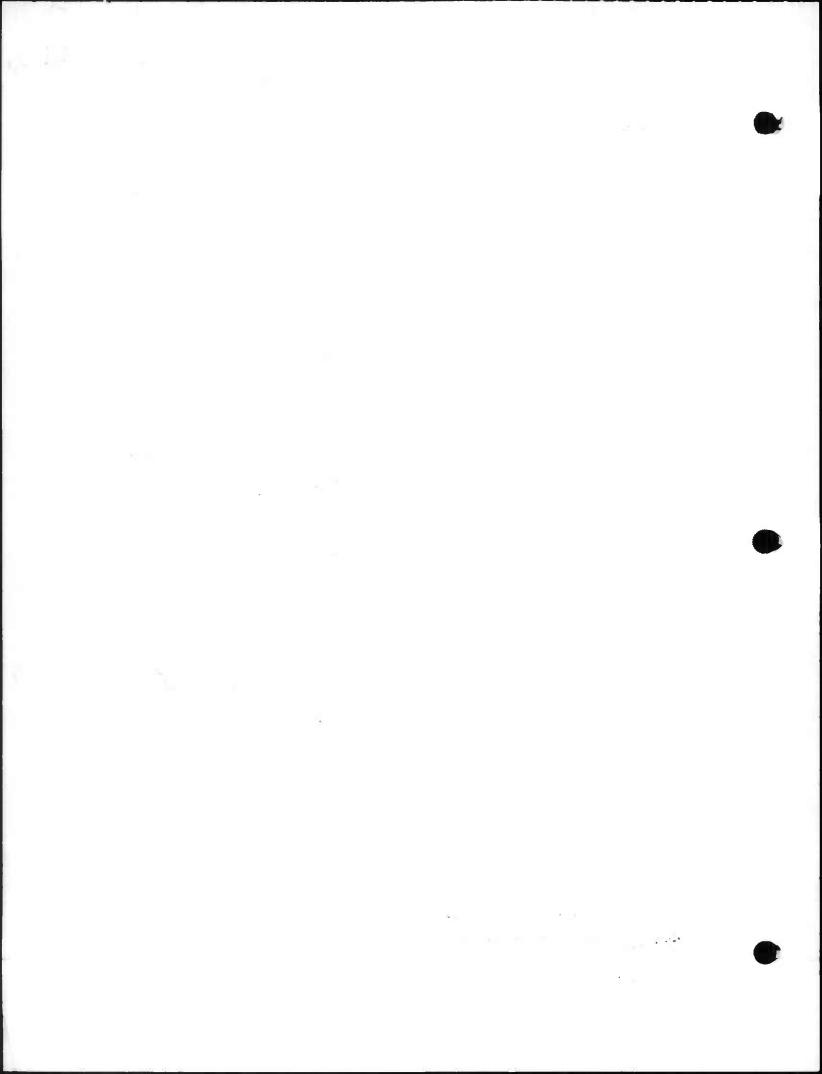


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21265-0020 IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-hours after death. Page 6 may be retained by the TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be directly filled in by the funeral director, page 5 should be directly within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CE	RTIFIC	ATE OF	DEATH	REG.	NO.			
1	1. DECEDENT'S NAME (First, Middle, Last) GERALDINE	MYERS				2. DATE OF DEAT MONTH NOV .		1995	3. TIME OF DEAT	н Рм
	4. SOCIAL SECURITY NUMBER 5. SEX $212-01-6508$ 1 \square M	6. AGE (In yrs. last		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTI (Month, Day, You Oct. 1	nr)	Countr	IPLACE (State or Form)	oreign
TOR	99. FACILITY NAME (If not institution, give street and institution give street and institution give street and institution give street and institution give street and institution give street and institution give street and give str	number)	96	Towso	R LOCATION OF DE		9c. CO	UNTY OF D	EATH	
DIRECTOR	10e. STATE 10b. COUNTY Maryland Baltimor	re	10c. CITY, TOWN OR LOCATION TOWSON						10d. INSIDE CITY LIMITS? 1 YES 2 X	
FUNERAL	10e. STREET AND NUMBER 503 Worcester Rd.		101. ZIP CODE 21 204			10g. CITIZEN OF WHAT C			WHAT COUNTRY?	NO
BY FUN	11. MARITAL STATUS 12. WAS FOR	S DECEDENT EVER IN U.S. ARRCES? 1 YES 2 ZAN ES, GIVE WAR OR DATES	ER IN U.S. ARMED 13. WAS DECENDENT OF HISPANII /ES 2 2 NO II yes, specify Cuban, Mexicen,			n, Puerto Ricen, atc.) Black, White			E — Amaricen Indi k, White, etc.	νn,
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete: Elementary/Secondary (0-12) College	d) (Gi	CEDENT'S USL ve kind of work Do NOT use re	JAL OCCUPATIO done during mos tired.)	N It of working	16b. KIND OI	BUSINESS/IN	IDUSTRY		
COMPLETED		yr.	Public	Relati	IONS 18. MOTHER'S NAM		11ege			
BE C	Henry (Ostendorf			Mary	C	onno11	y		
2	Mrs. Susan M. Aumille				nd Number or Rural A Ln. Ruxt			(ip Code)		
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from 4 Donellon 5 X Other (Specify)	stata 20b. PLACE A cemetery, crea	nd date of d	isposition (Ner place) Ey Cernet		/20/95 Li	LOCATION -	-		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Krat		22. NAME AN	hell-Wiede O York Rd.	feld Home				
CERTIFICATION	23. PART i. Enter the diseases, or complications that causes the desth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on the line. Approximate interval Between Onset and Desth disease or condition resulting in death) CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Bart I. 24a. WAS AN AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 24a. WAS AN AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO									
PHYSICIAN:	25. WAS CASE RE ENOUD TO MEDICAL EXAMINER? 1 YES, 2 W NO 1 Inc.		01	Check only one)	5 Reeldence 8	Other (Secretary				
ВУ РНУ	27. MANNER OF DEATN 286 1 Natural 5 Pending	e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	F 28c. INJL WOF	DRY AT	28d. DESCRIBE N	OW INJURY O	CCURED		
	2 Accident investigation 28e PLACE OF IN HIRV. At home farm street factors effice.							Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To	the best of my knowledge, de-	1 0		end place, and due t				e) end manner es s	tated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ALES OF PERSONANC CO		In Thype, P		29c, LICENSE NUM D2 45	69	•	11/1	(Month Day, Year)	
	Alah Chorofsky MD 31. DNUV 2 0 1995 July 32	515 Hairik	ount A	ve. Sui	te 320 T	owson, M	aryıan	<u>a ·</u>	-	



- 2	-	**OB: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2. 3 should	ifter death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
- 2	TO THE HOSPITAL OR ALLENDING PHYSICIAN.		be filed within 72 hours after death with the Sta	MPORTANT: If Item 28 is marked, or it

Iteml, Film729, 11/20/95, 1t

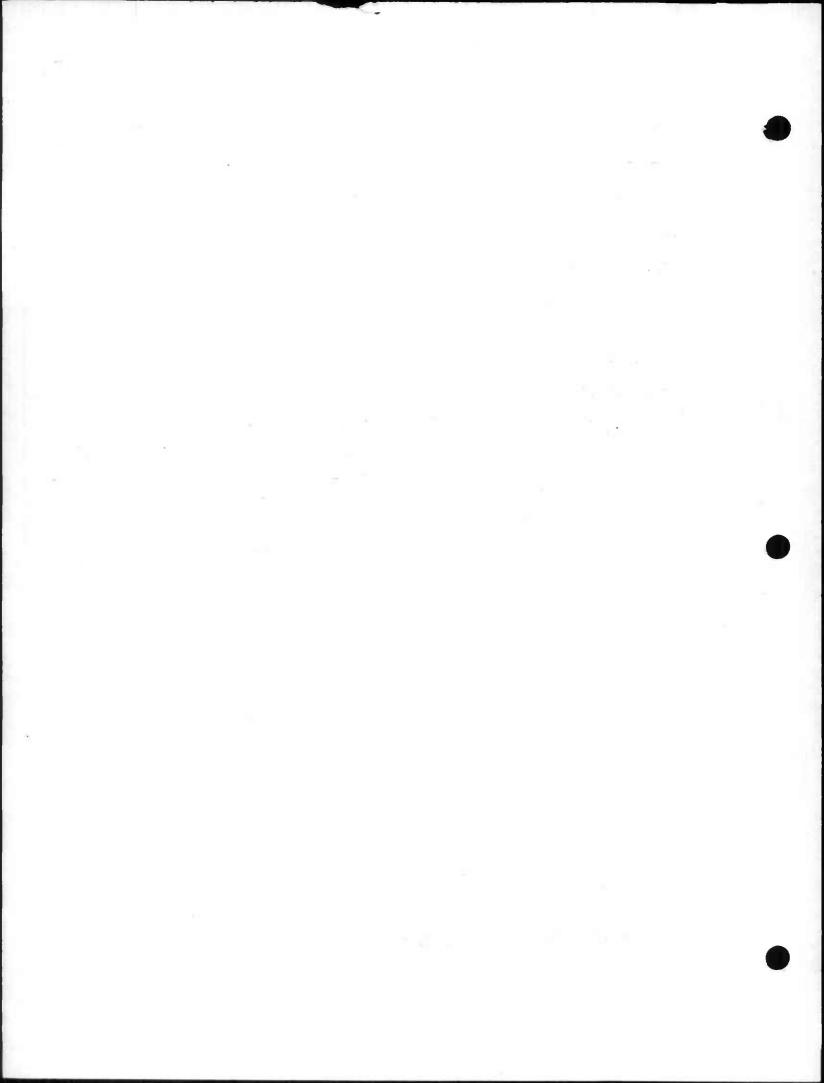
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

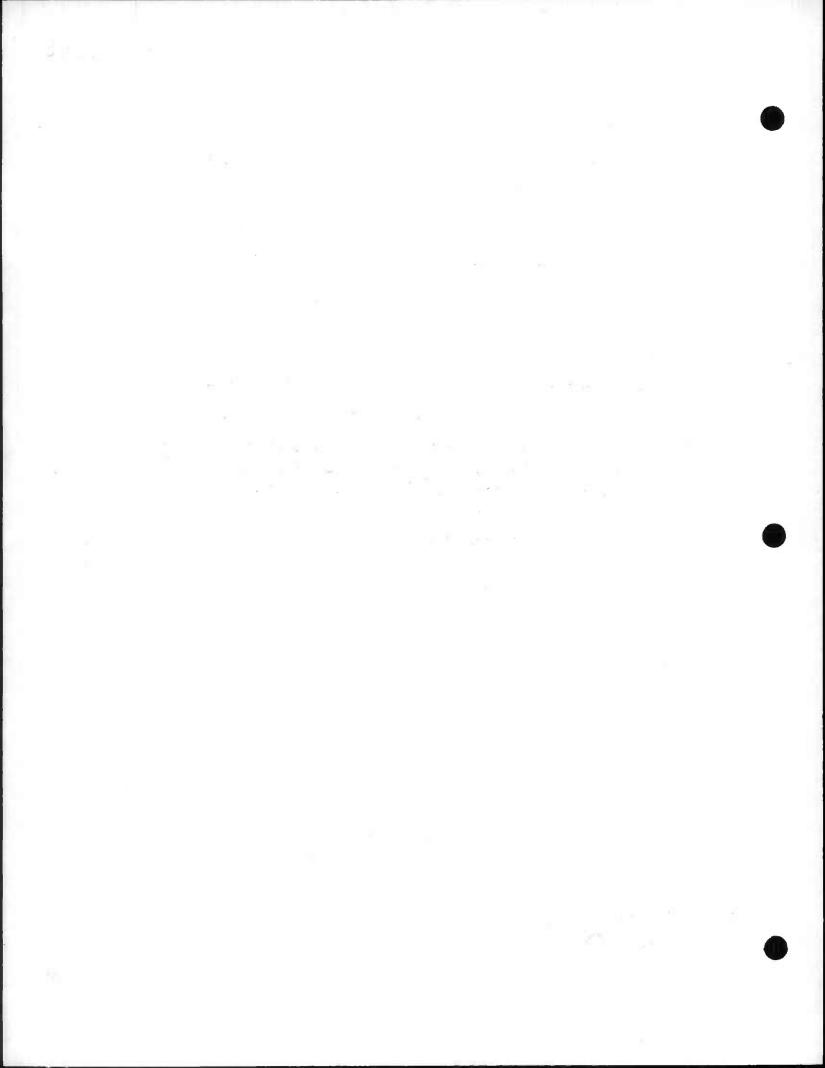
CERTIFICATE OF DEATH

REG NO.

	HEGISTHAH	CERTIF	CATE	T DEALL	REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Last) MADELINE ROSE	MOOR	E		2. DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE	"e 15"	YEAR 3. TIME OF OEATH	
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGI	E (In yrs. last birtnday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	/. DATE OF BIRTH		6. BIHTHPLAGE (State or Poreign	
	190-28-8697 1□M2×F	59 YRS.	MONTHS DA	YS HOURS MIN.	Aug. 28,	1936	Pennsylvania	
1	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH				ITY OF DEATH	
5			Ba	Baltimore City N/A				
UINECION	University Hospital RESIDENCE OF DECEDENT					1		
Í	10a. STATE 10b. COUNTY	10c. CITY	, TOWN OR LO			10d. INSIDE CITY LIMITS?		
5	Maryland Baltimore			Ea	lgemere		1 - YES 2 X NO	
בחארם	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZ	ZEN OF WHAT COUNTRY?	
	3109 Grace Road			212	19	Uni	ted States	
5	11. MARITAL STATUS 12. WAS DECEDENT EVER				VIC ORIGIN? (Specify Yes	or No-	14. RACE — American Indian, Black, White, etc.	
	1 Never Married 2 Married FORCES? 1 YE IF YES, GIVE WAR OR			i, specify Cuban, Maxica YES 2 □XNO Specify			Specify: White.	
٥							writte	
	15. OECEOENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S (Give kind of v	rock done during	PATION g most of working	16b. KIND OF BUS	SINESS/IND	USTRY	
2	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT us						
L L	10 Years	House	wife			wn Ho	me	
3	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden	Sumame)		
10	Dennis Scott				e LeBeau			
5	19a. INFORMANT'S NAME (Type/Print)				Route Number, City or Tow			
	Leroy J. Moore				mere, Mary			
		Ob. PLACE AND DATE Of			DATE 20c. LO		re, Maryland	
	4 Donation 5 Other (Specify)	ar Lawn C						
	111/1/1/		Dude	a-Ruck Fun	eral Home	06 D	undalk, Inc.	
	(par 11. Les	4	792	2 Wise Ave	. Dundalk	, MD	21222	
	23. PART I. Enter the diseases, or complications that cause shock, or heart failure. List only one cause on		ot enter the	mode of dying, suc	h as cardiac or respi	iratory sm	est, Approximate Interval Between	
	IMMEDIATE CAUSE (Finel	escii iiiis.					Onset and Death	
	disease or condition resulting in death)	ic car	diom	nopathy)			
	OUE TO (OR AS	S A CONSEQUENCE OF	Ť):	3				
2	Sequentially list conditions,							
	if any, leading to immediate	S A CONSEQUENCE OF	7):					
RIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury				-			
	that initiated events resulting in death) LAST	S A CONSEQUENCE OF	·);				i	
2	d							
١	PART II. Other significent conditions contributing to death	but not resulting	in the under	lying cause given in			24b. WERE AUTOPSY FINDINGS	
3	pulmonary hyperten:	sion			PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	2 7.					7	1 TES 2 NO	
3	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YE	S NO	UNCERTAI	N X			
3	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEAT				-		
n i siciain.	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/O	utpatient 3 DOA	OTHER:	Home 5 Realdence	8 Other (Specify)			
	27. MANNER OF DEATN 28s. DATE OF INJUR (Month, Day, Yes:		E OF 28c	. INJURY AT WORK?	28d. DESCRIBE HOW	NJURY OCC	URED	
-	1 Netural 5 Pending	, mu		YES 2 NO				
0	A Pactition	RY — At home, farm, a	street, factory,	office	281. LOCATION (Street City or Town, State)		or Rural Route Number,	
4	4 Nomicide determined	роспу			City or jown, state)			
OMPLE	29a. CERTIFIER (Check only	owledge, death occurre	ed at the time.	data and place, end due	to the cause(a) and ma	nner aa atat	ed.	
Na.	one) 2 MEDICAL EXAMINER: On the basis of exemina							
ا د	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU			E SIGNED (Month, Day, Year)	
9	n 2 Shali Mr)		are, Eroende No		D. DATE	s seems (morth, pay, rdllf)	
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF		Print)					
	MANSUR SHOMALL, M.D 22,			Baltind	re. mb 2	126		
	31. DATE FILED (MNO V 2001) 1995 32. REGISTRADES SH	GNATURE					-	
	NOV 2 () 1995 Julia 1846	CHATURE	÷.					



		1 - FOR STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTI	MENT OF H	HEALTH AND	MENTA	L HYGIEN	Ε		
		1. DECEDENT'S NAME (First, Middle, Last)	America Mar				2. DATE	OF DEATH		EAR	TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER N/A	1 - M 2X(X)F N/		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.		OF BIRTH		BIRTHPL Country)	ACE (State or Foreign
. 2, 3 should	RECTOR	Pa. FACILITY NAME (If not institution, give : Franklin Square RESIDENCE OF DECEDENT		9		or location of d	EATN		Balti	Y OF DEA	TH
permit. Pages 1,	ā	10a. STATE 10b. COUNT		10c. CITY, 1	TOWN OR LOCAT	TION Dund	alk			- 1	Od. INSIDE CITY LIMITS? YES 1/1/2 NO
ist	FUNERAL	2005 Bearridge					2122		Unit	N OF WH	at country? States
215-0020 attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1. XX Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 TYPES IF YES, GIVE WAR OR DATE	2 NO	If yes, sp	ecity Cuban, Mexico 2 NO Speci	en, Puerto	N? (Specify Yea Rican, etc.)	Yea or No— 14. RACE — American Indian, Black, White, atc. Specify: Black		White, atc.
10 o	LETED	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	CATION o completed) Coffege (1-4 or 5 +)	8a. DECEDENT'S US (Give kind of work life. Do NOT use n	k done during mo stired.)	ON est of working	161	. KIND OF BUS		TRY	
MARYLAND 2 retained by the hospital 5 should be detached to outlified at once.	COMP	N/A 17. FATHER'S NAME (First, Middle, Last)		N/	A	16. MOTHER'S NA	ME (First	Miridle Mairies	N/A		
RYL, ad by the lid be d	BEC	Jose Luis Mejia				Shell	ey D	ent			
ay be retained page 5 should to be notified	5	19a. INFORMANT'S NAME (Type/Print) Shelley Dent		2005 B	searrid		Apt	. 102	Dunda	ilk,	MD 21222
e 6 m ector,		20e. METHOD OF DISPOSITION 1	Uhil	Matery of other			18/1	995 T	owson,	May:	, stata Lyland
SALT death. e funera al. examin		21. SIGNATURE OF TUNERAL SERVICE LA	W. Lole		7922	Ruck Fun Wise Ave	. D	undalk	, MD	2122	2, Inc.
24 hours at filled in by lion, or remo		iMMEDIATE CAUSE (Final disease or condition	complicatione that coused to Liet only one couse on eec	h iine.		de of dying, auc	h aa car	diac or reapi	ratory arrest	t,	Approximata interval Batween Onaat and Daatt
executed within and completely o burial, cremat matic event, 1		resulting in death)	DUE TO (OR AS A C	ONSEQUENCE OF):						-	0.5 Hours
OX 68 be execution and or to bur	ATION	Sequentielly list conditions, if any, leading to immediate cause. Entar UNDERLYING	b. Extreme prema		(23 wee	eks gesta	atior	1)		_	
certificat nding phy Hygiene p	ERTIFICATION	CAUSE (Discess or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	DUE TO (OR AS A CONSEQUENCE OF):							
ing the	ICAL C	PART ii. Other eignificent condition	ne contributing to deeth but	not resulting in t	he underlying	g ceuse given in	Part I.	24s. WAS AN PERFOR 1 YES 2	MED?	Al-	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION DF CAUSE
requir	: MEDIC	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH VES		UNCERTAI			Ano		F DEATH?
VIIAL AN: The law inficate has t State Dept	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	The state of the s	PLACE OF DEATH		OTTERNA					
SICIAN certific the S	PHYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpati		☐ Nursing Nom	e 5 🗆 Rasidenca		FCRIBE HOW I	HIRV OCCUR	en.	
ATENDING PHYSICIAN: The law ECTOR: After this certificate has be stafe death with the State Dept.	ВУ Р	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJURY	M 1 D	PRK?	100.00	701101 11011 11			
OR ATTENDING DIRECTOR: After hours after death teem 28 is ma	ETEO	3 Suicide 8 Could not be 4 Homicide datarmined	28a. PLACE OF INJURY — building, atc. (Specify)	At home, term, atred	et, factory, office			ATION (Street a or Town, State)	nd Number or	Rural Roul	e Number,
보 보이트	COMPLET		CIAN: To the best of my knowled R: On the basis of examination as							ause(s) ar	nd menner eg stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	шШ	29b. SIGNATURE AND TITLE OF CERTIFIE	a Hay	_		29c. LICENSE NUI	MBER				onth, Day, Year)
5 5 8 W	10 B	The Lucia Feb. 30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CARE OF STATE	ATEM AT AT	-41	D 428	21		► 11	-14	-95
0		Dr. Melinda Ellio	tt 9000 Frankl	in Squar		Baltimor	e, M	arylan	d 2123	7	
d		NOV 2 0 1995	32 REGISTRAR'S SIGNATI	IL.							



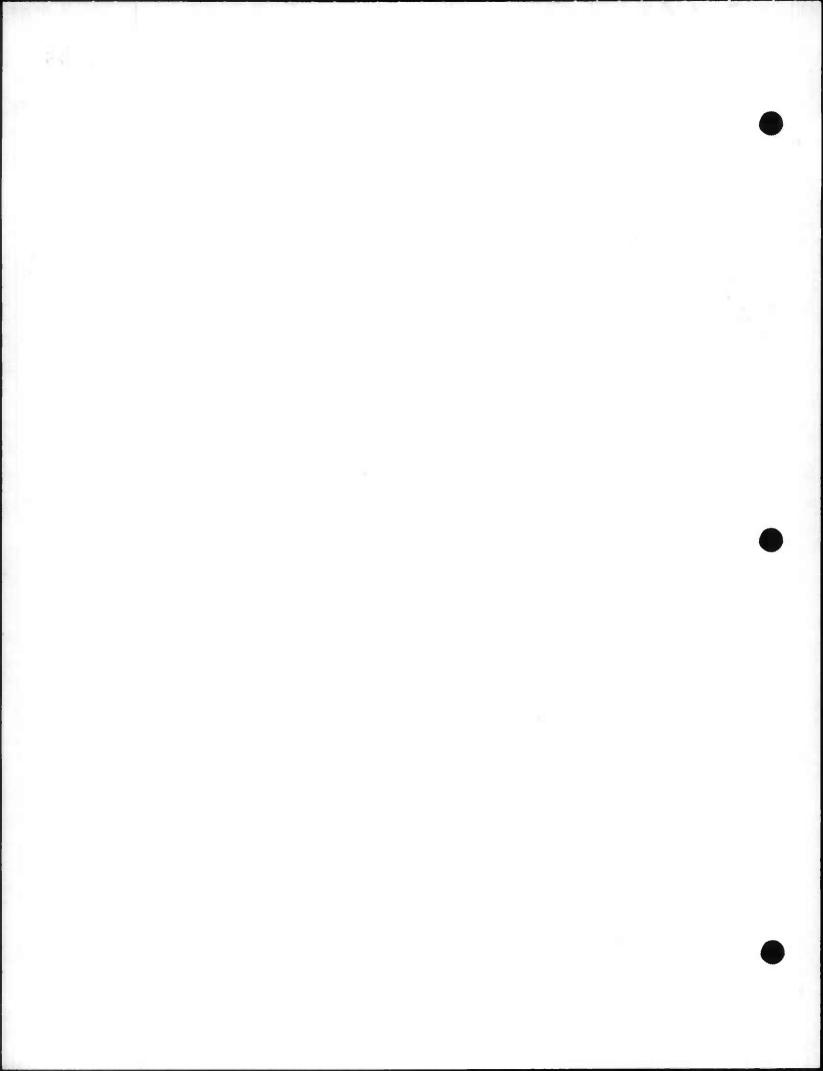
Amended: item #31 see item #32 per DVR (CYW) 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Leel) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Mary Elizabeth McNulty November 16 1995 9:00 PM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER t YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F DAYS HOURS MIN. 218-42-7788 94 02/ 20/1901 Ireland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5460 Addington Rd. N/A Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO MD. Baltimore N/A parmit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5460 Addington Rd. 21229 <u> Ireland</u> 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY BALTIMORE, MARYLAND 213 (Give kind of work done life. Do NOT use retired.) of working COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) the hospit should be detached Cook Healthcare 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Ħ McDonnell retained by Katherine Philbin BE notfilled 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 James L. McNulty 10198 Cabery Rd. Ellicott City, Md. hours after death. Page 6 may be 21042 8 20s. METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must funeral director, cemetery, crematory or other place) 4 Donation 8 Dother (Specify) Woodlawn Cemetery 11-20 Baltimore Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home athleer n and completely filled in by the to burial, cremation, or removal. 5311 Edmondson Ave. Balto. Md the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disesse or condition resulting in death) MEMSTATE 250VA executed within event, DUE TO (OR AS A CONSEQUENCE OF): DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate death certificate be by the attending physician and Mental Hygiene prior to Cause Enter LINDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO requires that апу signed b COMPLETION OF CAUSE 1 TES 2 NO DEATH? 1 YES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN PHYSICIAN: has b DR ATTENDING PHYSICIAN: The law 8 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate I HOSPITAL: OTHER: 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 1 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, this c 1 Natural 5 Pending М 1 YES 2 NO BY After Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 ED 8 Could not be DIRECTOR: / 4 Homicide 28 determined П 29a. CERTIFIER CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL TO THE HOSPITAL D
TO THE FUNERAL DI
Be filed within 72 ho
IMPORTANT: If 144 2 MEDICAL EXAMINER: O the basis of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29h, SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COM LETED CAUSE OF EATH (ITEM 27) (Type, Print) MO 01 31. DATE FILED (Month, Day, Year) 1995 Sight when Davidson Randall 02 2 ANO V

2

17/95



BALTIMORE, MARYLAND 21215-0020

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

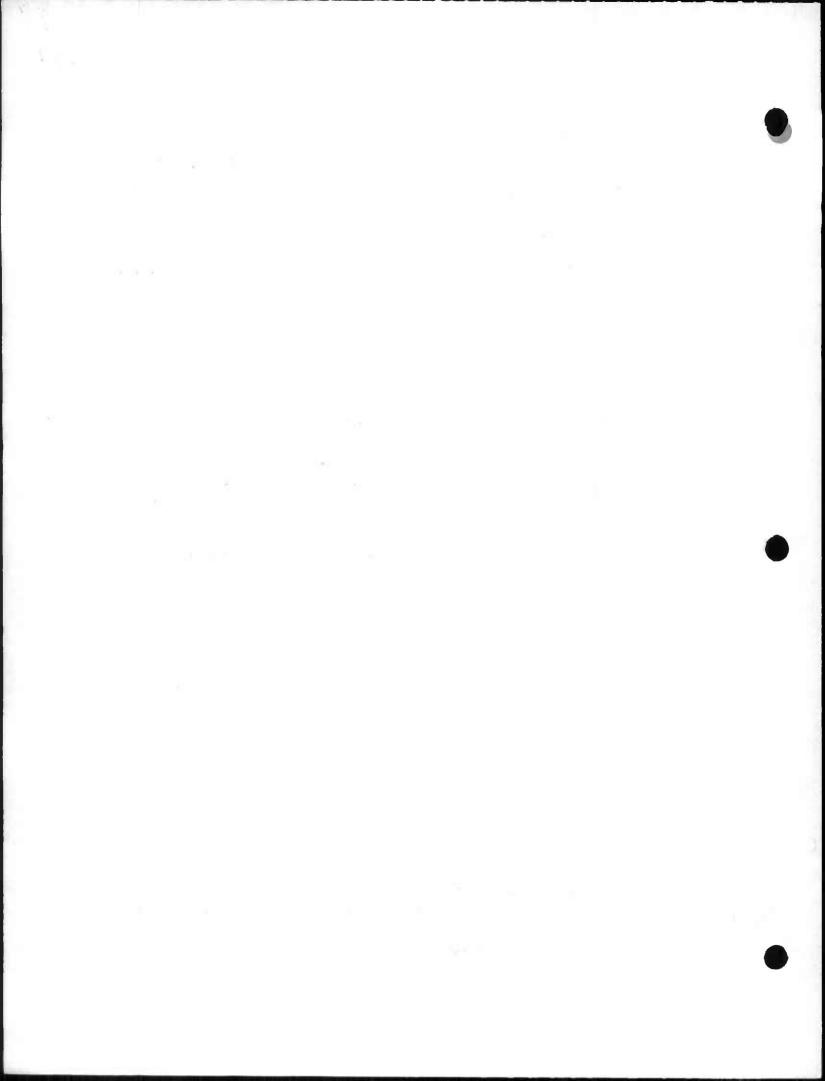
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should may within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
. 0	PECEDENT'S NAME (First, Middle, Last)		2. DATE O	E DEATH

	1 - STATE REGISTRAR	STATE OF F	C C	ERTIF	ICATE	OF	DEATH	MEN	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)								ATE OF DEATH	AW	YEAR	3. TIME OF DEA	тн
	AUSTIN NO	RTH SR.						NO			1995	1214	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	ast birthday)	IF UNDER		IF UNDER 24 HRS.		ATE OF BIRTH fonth, Day, Year)		8. BIRTI	HPLACE (State or Fi	oreign
	217-07-1796	1 XM 2 - F	75	YRS.	MONTHS	DAYS	HOURS MIN.		ril 28.	1920		aryland	
	9a. FACILITY NAME (If not institution, give s				9b. CITY	TOWN C	R LOCATION OF	DEATH		9c. CO	UNTY OF	DEATH	
DIRECTOR	UNION MEMORIAL	HOSPIT	'AL E.F	₹.	l B	ALT	IMORE (CITY N/A			N/A		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY										10d, INSIDE CIT		
#				10c, CITY, TOWN OR LOCATION					1				
	Maryland N/	<u>A</u>		Ba	ltim					Total and		YES 2 WHAT COUNTRY?	NO
١ ١						101	. ZIP COOE						
	3343 Chestnu							121			S.A.		
FUNERAL	1 Never Married 2 Married	12. WAS DECEDED	YES 2			If yes, sp	ecity Cuban, Maxid	can, Pua	NGIN? (Specify Yau irlo Rican, atc.)	II or No —	Blec	E — American Ind ck, White, atc.	ien,
R	3 Widowed 4 Divorced	IF YES, GIVE	WWII			1 TYES	2 NO Spec	cify:			Spec	White	
	15, DECEDENT'S EDU	CATION		ECEDENT'S	USUAL O	CCUPATIO	DN .	Т	16b, KIND OF BU	SINESS/IN	DUSTRY	WILLE	
- 1	(Specify only highest grade	completed)	S. S.	Give kind of fe. Do NOT u	work done	during mo	st of working						
۱ ۲	Elementary/Secondary (0-12)	College (1-4 or 5		abrio	Cut	ter		İ	Garment	t Ind	dusti	CV	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S N	NAME (FI	rst, Middle, Malden	Surname)			
	Belvey N	lorth			-		Glad	vs I	Mintor				
B	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	G AODRESS	S (Street a			Number, City or Tow	vn, State, 2	Zip Code)		
2	Mary North			3343	Che	stnu	ıt Avenu	ie.	Baltimon	re. 1	Marv]	land 212	11
	20a, METHOO OF DISPOSITION	HILL WARRY	20b. PLACE					_					
	1 G/Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	1 TrBurial 2 Cremation 3 Removal from State Cemation or other place											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE / / / / AME AND ADDRESS OF FACILITY												
	A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave, Baltimore, Maryland 21211												
_	23. PART I. Enter the diseases, or	_ /0 -	9/		The second second							cyland 2	
	shock, or heert feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	DUE TO DUE TO		EOUENCE (OF): OF):								
MEDICAL	PART II. Other eignificent condition							in Pert	I. 24a. WAS APPERFO	PMED?		b. WERE AUTOPSY AVAILABLE PRIOR COMPLETION DF DF DEATH? 1 YES 2	CAUSE
	DID TOBACCO USE CONT	RIBUTE TO CA					UNCERTA	AIN [
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF DE	OTHE								
2	XXVES 2 NO	1 Inpatient 2	XR/Outpatient	3 🗆 DOA			ne 5 🗆 Realdenc	6 D	Other (Specify)				
Ē	27. MANNER OF DEATH	26a. DATE O (Month,	F INJURY Day, Year)	26b. TI	ME OF		JURY AT ORK?	26d	. DESCRIBE HOW	INJURY C	CCURED		
В	1 X Natural 5 Pending 2 Accident Investigation				М	1 🗌	YES 2 NO						
	3 Suicide 6 Could not be 4 Homicide datarmined	28a. PLACE building	OF INJURY — At I	home, term.	atreet, fac	tory, offic	:0	28t.	LOCATION (Street City or Town, State		ber or Rural	l Route Number,	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	ER: On the best of										o(a) end manner ea	stated.
LI .	296. SIGNATURE AND TITLE OF CERTIFIE	R A a					29c. LICENSE N	UMBER		29d. D	ATE SIGNE	ED (Morith, Day, Year	7)
00	Dennis A	Christe	M				O.C.M	1.E		▶ V	.VOI	17,199	95
0	30. NAME AND ADDRESS OF PERSON WE Dennis Chute	HO COMPLETEO CA	ISE OF OFATH (II	Pen	n St	ree		_	nore, M	Mary	lan	d 21201	L
	NOV 2 0 1995	32. REGISTE	AR'S SIGNATURE										

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72. REGISTBAR'S, SIGNATURE

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DIRECTOR: After the hours after death vitem 28 is mark

TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho

physician and ne prior to

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the death certificate be

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

Items 24a&b 27,29d 11-20-95 Film 6729 W. H. Per Doct of MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (Coralee Maggie 2. DATE OF DEATH 3. TIME OF DEATH YEAR ENDON :57 M MCI 995 NOV. 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 7 DATE OF BIRTH 8. BIRTHPLACE (State or Foreign AUGUST 6.1899 SOUTH CAROLINA DAYS HOURS 24B-01-8262 1 M 2 F 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH BALTIMORE CITY DIRECTOR GOOD SAMARITAN HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE CITY BALTIMORE MARYLAND 1 X YES 2 NO FUNERAL 10e STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21239 USA 1317 E. BELVEDERE AVENUE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify 3 ☑ Widowed 4 ☐ Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 186 KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) N/A HOUSEWIFE HOUSEKEEPING-OWN HOME 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME /First. Middle. Maiden Surname! Unknown Unknown BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 SLATER AVENUE BALTIMORE, MARYLAND 21236 PATRICIA WRIGHT 20s, METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20a, METHOD OF DISPOSITION

1 X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) MORELAND MEMORIAL PARK NOVEMBER 13,1995 BALTIMORE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625 Claretto 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, euch as cardiac or respiratory strest, ahock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition DUE TO (OR AS A CONSCOUENCE OF): 3 days horacie reaulting in desth) 3 days emothorax CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate csuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
12 | Inpetiant 2 | ER/Outpetiant 3 | DOA **EXAMINER?** OTHER: t TYES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO BY 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Sulcida 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, desth occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED 95) BE D4617° NOV Hasse 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

610, BALTIMORE, MD

BALTIMORE, MARYLAND 21215-0020	after death.	by the funeral dire
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ALLENDING PHYSICIAN: The law requires that the death certificate be executed withmars hours after death. Page 6 may be retained by the hospital or attending physici.	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t

irial-transit permit. Pages 1, 2, 3 should nysician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the Key hours after death. Page 6 may be retained by the base TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIE	ENI
	C	ERTIFICATE	OF DEA	TH		DEG A	10

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR	TMENT	T OF H	IEALTH DEAT	AND I		GIENE i. NO.		04340
	1. DECEDENT'S NAME (First, Middle, Last) Helen Moore								2. DATE OF DEA	TH	95 YEAR	3. TIME OF DEATH 4:05 P
	4. SOCIAL SECURITY NUMBER 218-22-2963	1 □ M 2X F 6	(in yrs. last	birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTY	и	A BIRT	HPLACE (Stote or Foreign
OR	99. FACILITY NAME (# not Institution, give Meridian Multi					TOWN O	OR LOCATION	ON OF DE	ATH		altii	DEATH
DIRECTOR	nesidence of decedent 10a. STATE 10b. COUNT Maryland Bal	timore		10c. CITY, TOWN OR LOCATION Arbutus							10d. INSIDE CITY LIMITS? 1 YES 2 XNO	
FUNERAL	100. STREET AND NUMBER 105 Browns Ter	race				101	ZIP CODE			10g. CITIZEN OF WHAT COUNTI		
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	IN U.S. ARM 2 NO DATES	IED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Se					n, Puerto Ricen, et	fy Yee or No-	E — American Indien, k, White, etc.		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Giv life, I		e retired.)		ON st of workin	g		al Sec		- V
	17. FATHER'S NAME (First, Middle, Last)						100000000000000000000000000000000000000		ME (First, Middle, M	leiden Surname;		- <u>y</u>
TO BE	Abraham Panne 190. INFORMANT'S NAME (Type/Print) Diedre Durant	11	19b. 38	MAILING 03	ADDRESS	S (Street a	nd Number	lice or Rural R Ave.	Park Number, City Balto	or Town, State, 2	Zip Code)	1207
	20a. METHOD OF DISPOSITION 1	oval from State 20	b.PLACE AN	ND DATE (OF DISPOS	ITION /Ne				C LOCATION -	- City or Tr	own State
	21. BIQNATURE OF FUNERAL SERVICE LA	C.	~_		De	erri	ck (C. J	Jones Feights	'unera		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Dasth disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (QR AS A CONSEQUENCE QF): c. DUE TO (QR AS A CONSEQUENCE QF):											
MEDICAL O	PART II. Other significant condition	s contributing to death	but not re	sulting i	n tha un	deriying) causa g	Ivan in I	PE	AS AN AUTOPS'	Y 24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE C					UNC	ERTAIN				1 TYES 2 NO
PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inputient 2 ER/Out	26. PLACE		QTHE	₹:	e 5 □ Res	sidence (8 Other (Specif)	')		
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		28b. TIMI INJ	E OF URY M		URY AT RK? YES 2	NO	28d. DEŞCRIBE H	IOW INJURY O	CCURED	
	3 Suicide 8 Could not be determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At hom	e, ferm, s	treet, Jact	ory, office			28f. LOCATION (S City or Town,		er or Rural I	Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINE	CIAN: To the best of my know	vledge, deat	h occurre	nd at the ti	ime, date	end place,	end due t	to the ceuse(e) en	d manner as st	ated.	o) and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIES						29c. LICE					(Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON WH	Labora	TAN	27) (Type,		1	447	Yor	-ked	Ball	eria heri	Towars
	31. DATE FILED (Month, Day, Year) NOV 1 0 1995	20/MEGISTRAR'S PION	earung or Road	- 17						450	B	2/093

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TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fluorist force. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fluorist fluorist director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, certained, or removed.

IMPORTANT: If them 28 is marked, or Item 23 shows any injury, or other transmitte event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last) ELIZAB	ETH O'S	BRIEN	1	2. DATE OF DEATH MONTH	16-95	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 220-18-4082	10 H 2 XF 81		IF UNDER 1 YEAR IF UNDER 24 HRS ONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State & Foreign Stry) BALTIMORE			
OR	96. FACILITY NAME (II not institution, give s MEXIDIAN PE	RRING PKWY		b. CITY, TOWN OR LOCATION OF		BALTI				
DIRECTOR	10e, STATE 10b, COUNTY			TOWN OR LOCATION		10d. INSIDE CITY LIMITS?				
	100. STREET AND NUMBER	ltimore	<u> </u>	timore 101. ZIP CODE		1 ☐ YES 2 ▼				
FUNERAL	8126 Oakleigh	12. WAS DECEDENT EVER IN E FORCES? 1 YES	2 NO	21234 13. WAS DECENDENT OF HISP If yes, specify Cuben, Maxi	ANIC ORIGIN? (Specify Ye	U.S. s or No— 14. RAG Blo	A DE — American Indian, ok, White, etc.			
D BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDU	IF YES, GIVE WAR OR DAT	ES A	1 TYES 2 X NO Spe	city:	1	white			
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of wor life. Do NOT use i	k done during most of working etired.)		SINESS/INDUSTRY				
COM	17. FATHER'S NAME (First, Middle, Lest)		<u>Homemake</u>		HOME					
BE	Joseph P. Eppig		10h MAILING AL	Anna DDRESS (Street and Number or Run	M. Blakely					
2	John O' Brien		Date of the second	Dalton Road Ba	and the second second		122/			
	20g, METHOD OF DISPOSITION		LACE AND DATE OF	DISPOSITION (Name of		CATION — City or 1				
	Commetter 2 Commetter 3 Removal from State Commetter, Crematory or other place) Commetter 11/20/95 Balto MD									
	21. SIGNATURE OF PUNETAL SERVICE LAC) lh /	/	22. NAME AND ADDRESS OF						
	23. PART . Enter the diseases, or o	compligations that daused t	he death. Do not	7110 Belair enter the mode of dying, su	KORO BAITIM	ore. Mar	Approximate			
	IMMEDIATE CAUSE (Final disease or condition line desired and Death									
,	DUE TO (OR AS A ODNISEQUENCE OF): (RICE TO A LARGE LEVEL L'A PRINTE L'A PRINTE L'A PRINTE L'A PRINTE L'A PRINTE L'A PRINTE L'ANDRE L'									
ET	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
5	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	resulting in death) LAST	1	,				T			
A.	PART II. Other significant condition	s contributing to death but	not resulting in	the underlying cause given i	n Part I. 24s. WAS AN		b. WERE AUTOPSY FINDINGS			
MEDIC	Hogan	fezind	; p		1 □ YES 1		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
AN:	DID TOBACCO USE CONTR				IN 🖸					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL, EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpati	PLACE OF DEATH	THER:						
H	27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TIME (28d. DESCRIBE HOW I	NJURY OCCURED				
BY F	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJUR	WORK? M 1 YES 2 NO						
	3 Suicide 6 Could not be detarmined	26e. PLACE OF INJURY — building, atc. (Specify	- At home, term, stre	et, factory, office	28t. LOCATION (Street (City or Town, State)	and Number or Rural	Route Number,			
COMPLETED				at the time, date and place, and do			a) end menner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		Egs.	29c. LICENSE N			D (Month, Day, Year)			
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Pr		21/	DL	Nuravy			
4	31. NUV 1 8 1995 Ju	32 REGISTRAR'S SCHAT	URE	- mered	Tun Ter	rme Th	ux Center			

REG. NO.

FOR

1 - STATE REGISTRAR

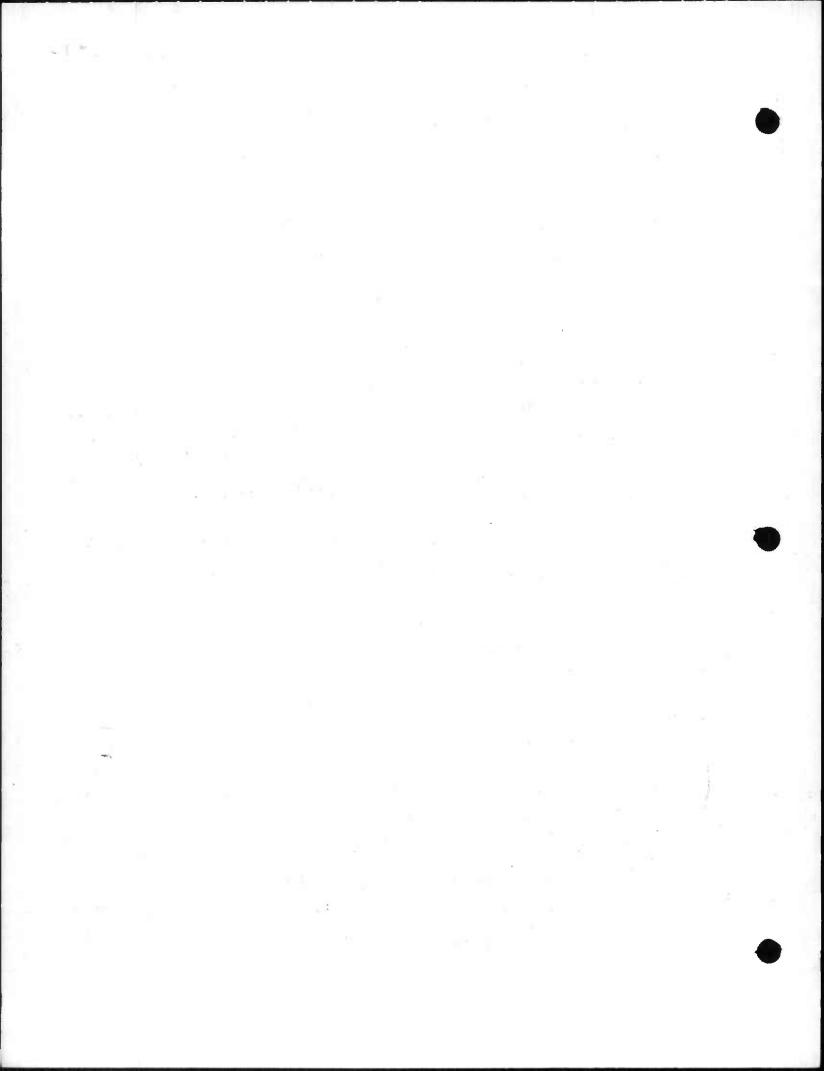
1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 3:40P Nov 15 Fannie Gordon Pomerance 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🗆 M 2 🗍 F DAYS HOURS 216 05 6411 Sept 21 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Montgomery General Hospital DIRECTOR Olney Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 - YES 2 NO filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 3701 International Drive 20906 USA retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 TES 2 XHO Specify: White BY 3. Widowed 4 Divorced Specify. COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ntacy/Secondary (0-12) College (1-4 or 5+) Homemaker own home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Noah Gordon Toba Max 70 BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15015 Redgate Drive Silver Spring, Md. 20905 2 Elizabeth Sakwa iours after death. Page 6 may be 9 20a_METHOD OF DISPOSITION

TET Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must Judean Memorial Garden 11/17 Olney, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE. 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Va. 22046 or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, Approximate ahock, or heart feilure. List only one cause on each line Interval Between **IMMEDIATE CAUSE (Finei** Onset and Death the disease or condition resulting in death) and completely fi o burial, cremation Cerebroroscular accident event, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, 2 if any, leading to immediate couse. Enter UNDERLYING the death certificate be signed by the attending physician Health and Mental Hygiene prior to CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST -PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? 1 YES 2 THO t. of Healt shows a 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN OR ATTENDING PHYSICIAN: The law has by Dept. 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL certificate to the State HOSPITAL: 1 YES 2 PNO 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Realdence 8 Other (Specify) 0 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT this cu marked, 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 COMPLETED 8 Could not be DIRECTOR: hours after of 4 Homicide 28 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. HOSPITAL FUNERAL within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 290 SIGNATURE AND TITLE OF PERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 195 (MD) D 11 15 Att whing D3474-5 ME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT FIELDS, MA: 18111 Prince Philip T-12 20832 0 31. DATE FILED (Month, Day, Year) NOV 2 0 1995 32. REGISTRAR'S SIGNATURE Durles

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



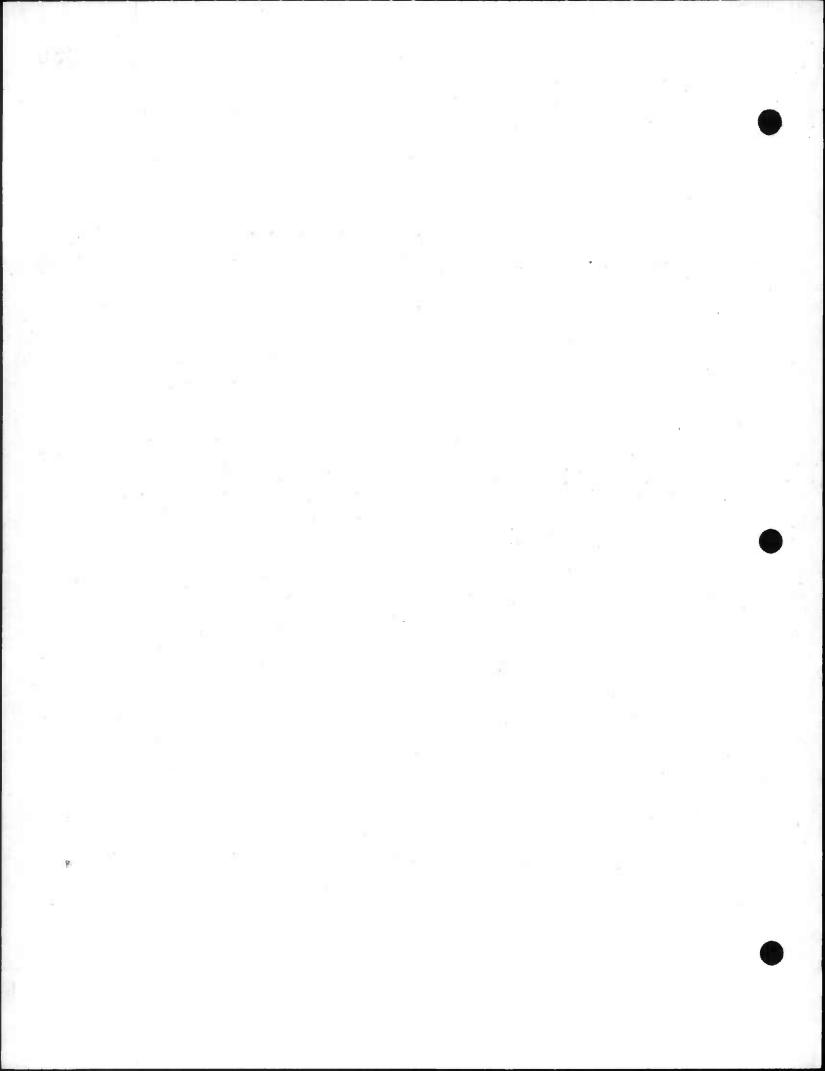
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			Ethel 4. SOCIAL SECURITY NUMBER	ROd 5. SEX 6. AGE	(In yrs. les	birthday)	ittle	AR IF U	INDER 24 HRS.	7. DATE OF B	11, 19	YEAR 95 8. BIRTH	3. TIME OF DEATH 4:15 A M PLACE (State or Foreign
3 should			577 54 2572 90. FACILITY NAME (If not institution, give s	treet end number)	2	YRS.	9b. CITY, TOV	WN OR LO	CATION OF DE		1000	OUNTY OF D	
. 2,		TOR	Montgomery Gen	eral Hospi	tal			0	lney		I M	iontg	omery
nit. Pages		DIRECTOR	10e. STATE 10b. COUNTY	,			shing		, D.C				10d. INSIDE CITY LIMITS? 1 YES 2 NO
n. ansit permit.		VERAL	100. STREET AND NUMBER 4449 Warren S	treet				101. ZIP	0016		10g. (USA	VHAT COUNTRY?
21215-0020 al or attending physician. for use as the bunal-transit		BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 2 VWidowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D	2 XN	MED O	If yes	, specify (NT OF HISPAN Cuben, Mexica NO Spec//	n, Puerto Rican,	ecify Yee or No-	- 14. RACE Black Speck	- American Indian, t, White, etc. hy: White
		COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Gi life.	ve kind of we Do NOT use	usual occup ork done during retired.)	ATION most of w	vorking		of Business/		WIII CC
/LA	d at once.	W	17. FATNER'S NAME (First, Middle, Last) Samuel Rod		110	Jilleilli	akei		MOTNER'S NA Sarah	ME (First, Middle	Maiden Surnami Kerman	0)	
	be notified	TO B	190. INFORMANT'S NAME (Type/Print) Nancy Rose							Route Number, Cl	ty or Town, State, PA	Zip Code) 1909	6
MOR age 6 m director,	must		20g. METHOD OF DISPOSITION 1. Burlel 2 Cremetion 4 Donation 5 Other (Special 21. SIGNATURE OF FUNERAL SERVICE AND	pred from State Cent	netery, crer	no date of natory or oth IST		eme	tery	11/1	20c. LOCATION 3 Wash	- City or Too lingt	on, D.C.
ALT death.	l examiner		Otens	Ken	de	_	Ive Fal	s P ls	Churc	n Fun	eral H rginia	2	2046
within 24 houndling the light of the light o	event, the medical e	(MANEDIATE CAMPE (EL-a)	List only ona cause on a	ach iina.					h as cardiec (or respiratory	arrest,	Approximata Interval Between Onset and Death
Trificate be executed g physician and con	W	ERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
S, P.C death cer e attendin		0	resulting in death) LAST	J									-
FECORD requires that the sen signed by the	any	MEDICAL	PART II. Other algorificant condition	Fig. 1	out not re	reulting in	the undari	ying cau	aa given in		WAS AN AUTOPS PERFORMED? YES 2 LING		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
		SICIAN: M	DID TOBACCO USE CONTR				N (Check only o	U U	NCERTAIN	V 🗆			1 - YES 2 NO
SICIAN: The lan		PHYSIC	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN	HOSPITAL: 1 Inputient 2 ER/Outp	patient 3	□ DOA				8 Other (Spe			
ON OF DING PHYSIC After this ce	mar	À	1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY	/ — At hor	28b. TIME INJU	M 1	INJURY A WORK? YES			E HOW INJURY (
TEN S	m 28 i	LETED	4 Homicide determined	building, atc. (Spec	cify)					City or Tow	n, State)		oute Number,
물물	7 ==	COMPL	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the bast of my know									end menner ee stated.
의 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기	IMPORT	шШ	296. SIGNATURE AND TITLE OF CERTIFIER						I F C		29d. D	ATE SIGNED	(Month, Day, Year)
25			30. NAME AND ADDRESS OF PERSON WHO A L bert Rich	> TEZ TELL	ATN (ITEM	27) (Typo, F	Ter:	ne Fre	mal	drive.	S. Sprl	P.1	12 20906
			NOV 2 0 1995	L. WESTERS CON									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTI	FICAT	E OF	DEATH		RE	EG. NO).			
	1. OECEDENT'S NAME (First, Middle, Last)							DATE OF O				3. TIME OF DEA	TH
	ELIZABETH BURNETT	PIRIE						OV.	15.	199	YEAR	3:00	D M
	4. SOCIAL SECURITY NUMBER 5. SEX		(In yrs. lest birthda	/) _IF UNDE	R 1 YEAR	IF UNDER 24 HRS.	7. 0	ATE OF B	RTH	1,75		HPLACE (State or F	
	218-38-4921 1 D M 2	₩ F	92 YRS.	MONTHS	DAYS	HOURS MIN.		Month, Day,		1002	Count	ry)	
	9a. FACILITY NAME (If not institution, give street and num	ber))2	9b, CIT	Y. TOWN (OR LOCATION OF		L. I	<i>)</i> , .	1903	T I C	rida	
Œ.	Greater Baltimore Medi		+										
81	RESIDENCE OF DECEDENT	Car Cen	iter		Cowso	on		Baltimore					
DIRECTOR	10e. STATE 10b. COUNTY		10c. C	ITY, TOWN	OR LOCAT	TION		10d.					Υ
0	Maryland Baltimore		l E	altin	ore				LIMITS?	NO			
AL	10e. STREET AND NUMBER		101. ZIP CODE						WHAT COUNTRY?				
8	231 Regester Avenue		21212								II.S.	٨	
FUNERAL	11. MARITAL STATUS 12. WAS DE	CEDENT EVER I	N U.S. ARMED	13.	WAS DEC	ENDENT OF HISP	ANIC OF	RIGIN? (Sp	ecify Ye		14. RACI	E — American Ind	len,
	IE VES	S? 1 YES	2 ty NO		If yea, sp	ecify Cuben, Mexi- 2 NO Spec	cen, Pu	erto Rican,	etc.)		Spec	k, White, atc.	
BY	3 Widowed 4 Divorced					X	,				-	white	
빌	15. DECEDENT'S EOUCATION (Specify only highest grade completed)		16a. DECEDENT	'S USUAL C	CCUPATIO	ON st of working		16b. KIND	OF BU	SINESS/IND	DUSTRY		
9	Elementary/Secondary (0-12) College (1-	4 or 5 +)	ille. Do NOT	use retired.)	ourng mo	or or morning							
₫.	1 yea	r	Homem	aker	er Own Home								
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAI												
BE (William Henry Burnett		Fannie Smith										
10	19a. INFORMANT'S NAME (Type/Print)		nd Number or Rum					Code)					
ř	William S. Pirie Jr.		231	Reges	ter	Avenue	Bal	t.imo:	re.	MD 2	1212		
	200. METHOD OF DISPOSITION	20b	PLACE AND DAT	FOFDISPO	SITION /No	ma of		DATE	200 10	CATION	City on To	Ctata	
	1 Burlet 2 Commetton 3 Removal from State armstery, cromatory of observations of Discosino S A Other (Specify Entombnent Dulaney Valley Mem. Gdn's 11/18 Timonium, Mar											amil and	
	22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Inc.												
		K	()										
_	23. PART i. Enter the disesses, or compilcation	New		6	500	York Rd	. B	altir	nore	MD	212	12	
	shock, or heart failure. List only one ceuse on each line. Interval B Onset and Interval B Onset and Due to (or as a consequence of):												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												
N: MEDICAL		PERFORMED? 1 YES 2 XNO OI									WERE AUTOPSY F AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2	TO CAUSE	
Z I	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE										
S	EXAMINER? 1 YES 2 VNO 1 Minpatle		etient 3 🗆 DOA	OTHE A Nu		e 5 🗆 Reeldence		Other /Sne	olb)				
PHYSICIAN:	27. MANNER OF CEATH 28e. D.	ATE OF INJURY	28b. T	ME OF	28c. INJ	URY AT	_			NJURY OC	CURED		
	1 X Netural 5 Pending	lonth, Day, Year)		NJURY M		RK? (ES 2 NO							
B	2 Accident Investigation 3 Suicide 8 Could and by 28e. Pl	LACE OF INJURY	— At home, ferm	, street, fec			281	LOCATION	/Street	and Number	or Rural F	Route Number,	
	4 Homicide 8 Could not be by	illding, atc. (Spec	cify)	,,	,			City or Tow			or norei r	NODIO NUMBER,	
COMPLETED	29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the one) 2 MEDICAL EXAMINER: On the beau) end menner es s	stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE											(Month, Day, Year)	
	9 17							D-44560 ► Nov. 16,					95
요	30. NAME IND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
	Jeffrey Alexander M 31. DATE FILED (Month, Day, Year) 32 RE	D. 66	0 Ken	i.1wo	rth	Dr. To	ws	on,	MD	2120	04 5	Suite 2	202_
	31. NOV 2 0 1995 Juli 31 RE	derlas	6.86										

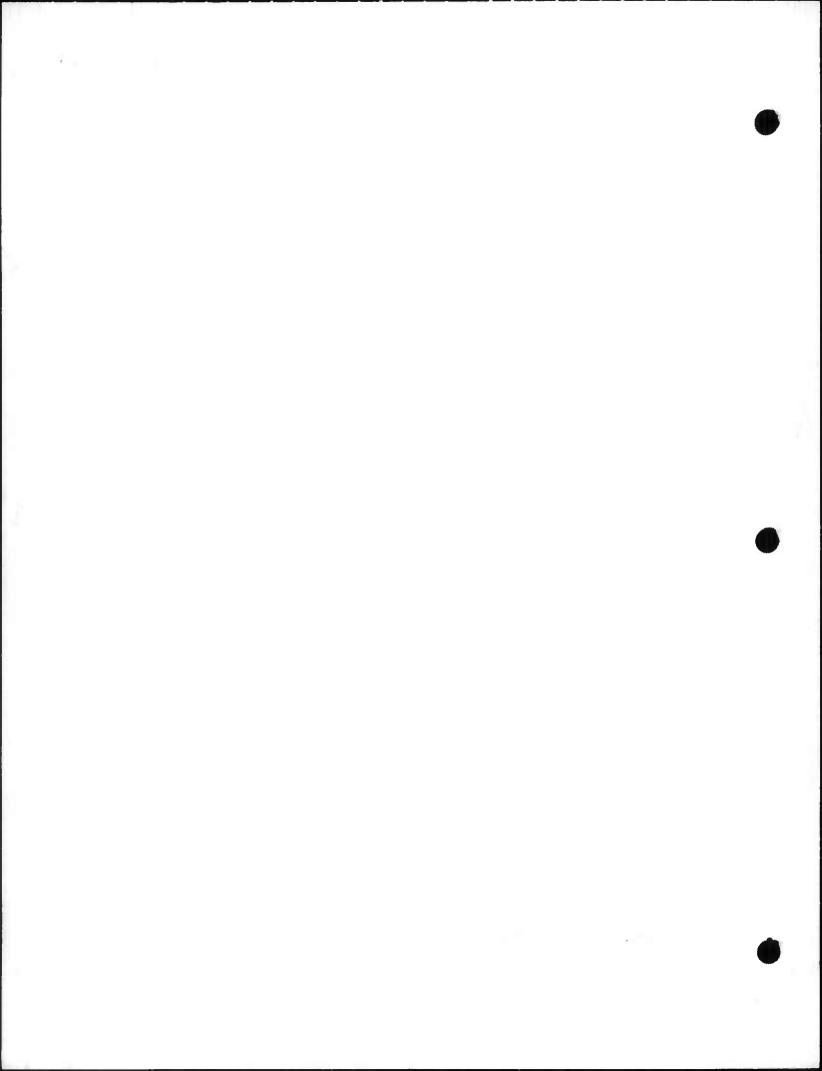
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the funeral distribution or the most provided that the certificate has been signed by the attending physician and completely filled in by the funeral distribution to the most perfect of the certificate has been signed by the attending physician and completely filled in by the funeral distribution to removal.

IMPORTANT If them 28 is marked at the certificate has been signed by the attending prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89



J 1	DIRE	IOU. STATE	IOU. COOM I			IUC.
	٥	MARYLAND	BAL	TIMORE		
8	₩.	10e. STREET AND NUMBER				
020 physician. burial-transi	FUNERA	10 THORN H	ILL ROA	AD		
lciar al-tra	5	11. MARITAL STATUS		12. WAS DECEDENT EV		
D20 ohys		1 Never Married 2	Merried	FORCES? 1 1		0
or attending physician	B	3 Widowed 4 🙀 Divo	rced	IF TES, GIVE WAR O	M DAIES	
15 tend	8		EDENT'S EDUC		16a. DEC	CEDE
or affe			y highest grade ((Gh	ve kind Do No
D 21		Elementery/Secondery (0		College (1-4 or 5+)	٩	CH(
AND 2 the hospital detached fo	COMPL	17. FATHER'S NAME (First, M		4 YEARS		CII
2 8 8 Z		J. MARION				
MAR retained 1 5 should	BE	19. INFORMANT'S NAME (7	Type/Print)		198	MAN.
M/ retal 5 sh noti	5	RUTH KUEHN	E.		1	93!
May be		20a. METHOD OF DISPOSIT			20b.PLACE A	
OR may ector, p		1 KBurlel 2 - Cremetic	n 3 🗆 Remo	oval trom State	cemetery, crer	natory
	- 5	4 Donation 5 Other 21. SIGNATURE OF FUNERA		******	MORE	LA
ALTIN death. Pag tuneral dir i.	1	21. SIGNATURE OF FUNERA		Charle		_
BALT er death. the funera wal.		1 9/1	N	/		
E > 0 3		23 SARFT. Epter the d	meases, or c	omplications that cer	used the de	ith. !
5 = 6		mock, or h	eert fellure. I	List only one ceuse of	on each line.	
74 ho filled tion, o		IMMEDIATE CAUSE (Fir	nel	1. 1	- /	200
within 24 in pletely fille cremation,		disease or condition reaulting in death)	→ ,	arter	iosel	ex
3760 completely filled completely filled ial, cremation, o	l li			DUE TO (OR	AS A CONSEC	UENC
BOX 6876(zate be executed w hysician and comp e prior to burial, cr er traumatic eve	z					
OX 68: e be executi sician and c rior to burie traumatic	CERTIFICATION	Sequentielly list condit if any, leading to imme	iona,		AS A CONSEC	UENC
30) ste be ysiciar prior trau	X	cause. Enter UNDERLY	ING			
O. B ertificate ing phys rgiene p	畄	CAUSE (Disease or Injuthet initieted events	, עוו	DUE TO (OR	AS A CONSEC	UENC
P.O. E sth certifica tending phy all Hygiene or other	토	resulting in death) LAS	т			
DS, P.O. BOX he death certificate be of the attending physician Mental Hyglene prior to njury, or other traun				1	an Lauren	
DS, the deal the att d Menta injury,	ا ب	PART II. Other significe	ent condition	s contributing to dee	th but not re	esult
ORE that the the ed by the and the and in	호	(e)	relver	orcular a	ALL DO	M
puires that signed I Heafth a pws amy	MEDICAL					
RECORDS, requires that the despen signed by the at t. of Health and Menta shows any injury,		DID TORACCO I	ICE CONITE	DIDLITE TO CALIC	F OF DEA	TLI
AL F he law r has be bept. n 23 s	CIAN:			RIBUTE TO CAUS	26. PLAC	
VITAL IAN: The law rifficate has the State Deption or item 23	5	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	26. PLAC	E OF
E VITA	PHYSI	1 TYES 2 NO		1 Inpatient 2 ER	/Outpatient 3	
YSIC YSIC S Cer th th th	Ħ	27. MANNER OF DEATH		26e. DATE OF INJU	JRY	26b
NG PHYSI frer this coath with marked,	ВУБ		Pending Investigation	(11107111) Day, 71	,	
After the death		2 Accident 3 Suicide		26e. PLACE OF IN-	JURY — At ho	me, ta
TEN TEN TOR: after 28 is	ED	4 Homicide	Could not be determined	buttding, etc.	(Specify)	
DIVISION OF VITAL RECORDS, P.O. BOX 6876(OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIRECTOR. After this certificate has been signed by the attending physician and completely nours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation item 28 is marked, or item 23 shows any injury, or other traumatic event,	Ш	29e. CERTIFIER	TIPVINO BUTTO			
_ ₹ ₹ ₹ ₹	AP	onel -		CIAN: To the best of my		
	COMPL	2 MED	ICAL EXAMINE	R: On the beele of exami	nation end/or i	rivest
		29b. SIGNATURE AND TITLE	OF CERTIFIER	3		
	BE	Merra	KI	nluclu	1	
₽ ₽ a ¥	임	30. NAME AND ADDRESS O	F PERSON WH	O COMPLETED CAUSE O	F DEATH (ITE	W 27)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR EDITH OWINGS **PYCHA** NOVEMBER 1995 12:55 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS t 🗌 M 2 💢 F 217-24-3991 85 3/22/10 MARYLAND 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MERIDIAN CROMWELL N.H. TOWSON BALTIMORE CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 TYES 2 NO LUTHERVILLE tog. CITIZEN OF WHAT COUNTRY? 10f ZIP CODE 21093 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 YES 2 NO Specify: Specify: WHITE IT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working of work done of use retired.) OOL TEACHER SCHOOL SYSTEM 18. MOTHER'S NAME (First, Middle, Meiden Surname) M. ELMA DONN LING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 FRAMES ROAD BALTIMORE, MD 21222 ATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 11/15/95 HILLENDALE, MD ND MEMORIAL PARK 22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD TOWSON. MD 21286 Do not enter the mode of dying, such as cerdiec or reapiratory arrest, Approximate Interval Between Onset and Death The covering artery disease E OF CE OF 24a. WAS AN AUTOPSY PERFORMED? ing in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO

1 - YES 27 NO

COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO

11-13-95

TO	CAUSE	OF	DEATH	YES		NO		UNCERTAIN	Z
		26	PLACE OF	DEATH	(Checi	k only o	ine)		

OSPITAL: Inpatient 2 ER/Outpatient	DOA 4	THER:	☐ Residence (5 Other (Specify)	
26e. DATE OF INJURY (Month, Day, Year)	26b. TIME O		AT	26d. DESCRIBE HOW INJURY O	CCURED

M 1 YES 2 NO ırm, street, fectory, office

261. LOCATION (Street end Number or Rural Route Number, City or Town, State)

				_													
ccurred	at	tha	time,	date	end	place,	end	due	to th	e cer	180(0) end	menn	er a	e at	isted	1.
igation,	ĺn	ту	optni	on, d	eath	occur	ed at	the	time	date	end	placa	, end	due	to	the	ca

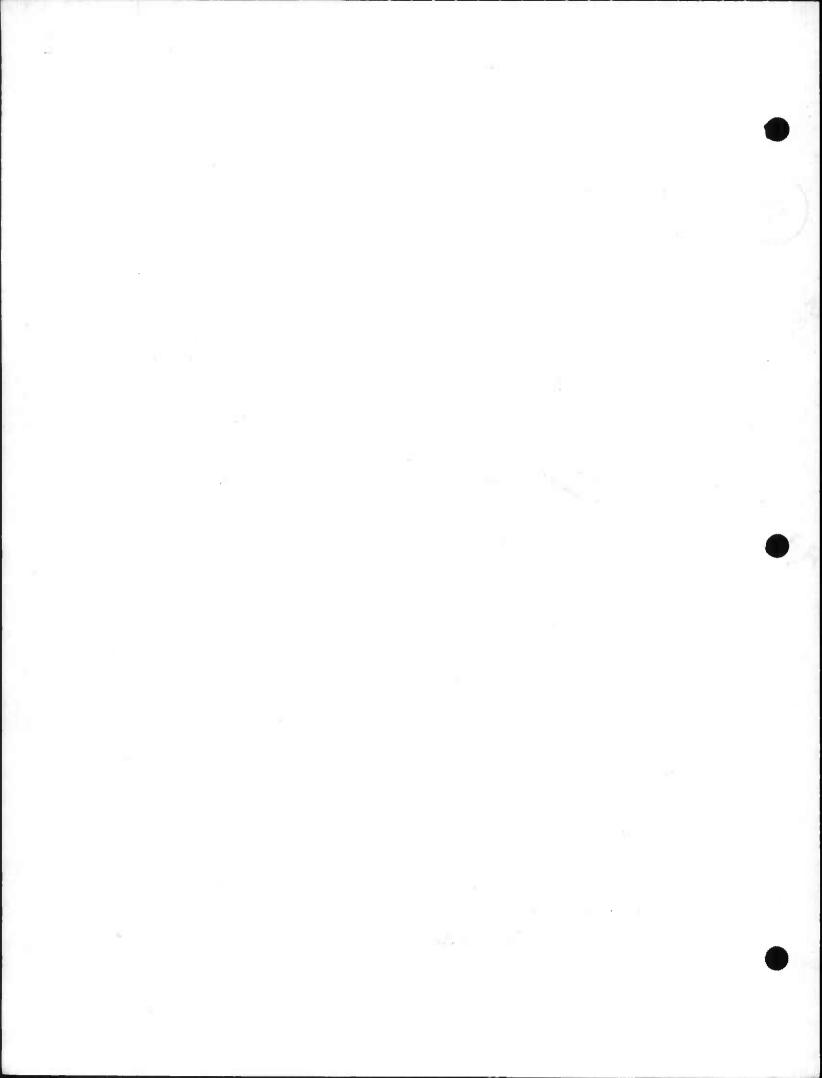
021022

imination end/or investigation, in my optnion, d	eath occured at the time,	date end place,	end due to the caus	se(e) end menner ee state	rd.
	29c. LICENSE NUMBER		29d, DATE SIGN	NED (Month, Day Year)	

							_		_
NAME	AND	ADDRESS	OF PERSO	N WHO	COMPLETED	CAUSE	OF	DEATH (ITEM 27) (Type, Print)	_

8604 HARFURD Nel

MARION KONALEUSIU 86
TE FILED (MONTH, Day, Vear)
10V2 1995 July Studion Ranks



1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
1. DECEDENT'S NAME (First, Middle, Lest)	/ N	\			2. DATE OF DEATH MONTH	DAY YEA	3. TIME OF DEATH				
JEANNETTE	ROANE (Mean				NOV. 17	, 1995	0942 A M				
4. SOCIAL SECURITY NUMBER 217-24-6156	5. SEX 8. AGE (ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 14	,1920 s.B.	IRTHPLACE (State or Foreign Ountry) Virginia				
99. FACILITY NAME (If not institution, give s 1825 NORTH MIL		91		OR LOCATION OF DE	ATH	9c. COUNTY C					
RESIDENCE OF DECEDENT						IN	/ A				
10e. STATE 10b. COUNT			OWN OR LOCAT				10d. INSIDE CITY LIMITS?				
Maryland 100. STREET AND NUMBER	N / A	Bal	timore	ZIP CODE		Ina CITIZEN	1 YES 2 NO				
1825 N. Milto	n Avenue			21213		US					
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA		IIC ORIGIN? (Specify Yon, Puerto Ricen, atc.)	S	RACE American Indian, Black, White, etc. Specify:						
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	ON est of working	16b. KIND OF BU	JSINESS/INDUSTR	lack						
Elementary/Secondary (0-12) 12 th	College (1-4 or 5 +) N / A	ine. Do NOT use n	ician		Hosp	ital					
17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide						
Doctor Roane 19s. INFORMANT'S NAME (Type/Print)		19h MAILING AF	INDERS /Street		e Burrow						
Michael Roane					Balto.,M						
20c. METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, cremeter											
21. SIGNATURE OF FUNERAL SERVICE LIN		022.0		ND ADDRESS OF FA	CILITY						
Coulton	C. Dong	and	11701	McCull	Carlto oh St., B		glass Md.21217				
23. PART I. Enter the disesses, or shock, or heart failure.	complications that cause on a		enter the mo	de of dying, suc	h as cerdiac or res	piratory srrest,	Approximate Intarval Between				
IMMEDIATE CAUSE (Final disease or condition	Arteriosc	lerotic	Cardi	ovaccul	ar Dicos	160	Onset and Death				
resulting in death)		CONSEQUENCE OF):	Carar	ovascar	ar bisco	136					
Sequantially list conditions,	b. DHE TO (OR AS A	CONSEQUENCE OF):									
if any, leading to immediate cause. Enter UNDERLYING	- DOL 10 (ON AS A	CONSECUENCE OF J.					į				
CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):									
reaulting in death) LAST	d										
PART II. Other aignificant condition	na contributing to death b	ut not reaulting in	the underlyin	g causa givan in		N AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
					1 YES	1	COMPLETION OF CAUSE OF DEATH?				
			F7 110 F	7		ECTION	1 TYES 2 NO				
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES 26. PLACE OF DEATH			и П						
EXAMINER?	HOSPITAL:	T 6	THEO.		6 Other (Specify)						
27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME (OF 26c, IN.	URY AT	26d. DESCRIBE HOW	INJURY OCCURE	D				
1XXNatural 5 Pending 2 Accident Investigation	(Moran, Day, 10as)	INJOH		YES 2 NO							
3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, etc. (Spec	- At home, ferm, stre	et, factory, offic	ia.	281. LOCATION (Street City or Town, Stet		urel Route Number,				
1 CERTIFYING PHYS	ICIAN: To the best of my know	ladge, death occurred	at the time, date	end place, end due	to the cause(s) end m	anner es atated.					
2X XMEDICAL EXAMIN	ER: On the basis of exeminatio	and/or investigation,	in my opinion, o	leath occured at the	time, date and place, o	end due to the cau	use(e) end manner ee stated.				
296 SIGNATURE AND TITLE OF CONTIFIE	B 0	1.1		29c. LICENSE NUI	MBER	29d. DATE SIG	NED (Month, Day, Year)				
7777	. 0	() ₍ (N NTOT					
TAME AND ADDRESS OF PERSON W	rhen	ATH (ITEM 27) (See 2	vert)	O.C.M		▶ NOV					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 5 should be detached for use as the burial-transit permitted within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 6876

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day,

32. REGISTRAR'S SIGNATURE S661 0 3 AON

DHMH-18 Rev 1/89

PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the di	ificate has b	be filed within 72 hours after death with the State Dept. of Health and Mer	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury

•											9	5	3495	4
	1 - STATE REGISTRAR	STATE OF MAR			TMENT ICATE				MENTA	L HYGIENI REG. NO.	E			
- A	1. DECEDENT'S NAME (First, Middle, Last)			_					2. DATE	OF DEATH	٧	YEAR	3. TIME OF DEAT	ГН
	RAYMOND		ROH	- 01									10:15 P	
	4. SOCIAL SECURITY NUMBER 212-26-7574	5. SEX 6. /	AGE (in yrs. lest	birthday)	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE	of BIRTH h. Day, Year) 5.16,19	Country)			oreign
	9a. FACILITY NAME (If not institution, give st	7	9b. CITY, TOWN OR LOCATION OF D						-	10,15		yland		
œ	Stella Maris Hospi					TOWN O	R LOCATA	ON OF DE	EATH.			TY OF DE		
5	RESIDENCE OF DECEDENT	LCE			100	15011					Dal	LUTING	ore	_
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O								10d, INSIDE CITY LIMITS?	,
	Maryland Balti	more			RaT	tımo	re (Count	zy .				1 YES 2 X	NO
FUNERAL	100. STREET AND NUMBER 3213 Putty Hill Av	/e.				101.	ZIP COD		10g. CITIZE				HAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? XX	ECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPAN 15. Y € 2 □ NO 16. Y € 8. Specify Cuben, Maxica 1 □ Y € 1					n, Puerto		or No-	14. RACE Black Specifi	- American India, White, atc.	an,	
	15. DECEDENT'S EDU	CATION	18a, DE	CEDENT'S	USUAL OC	CUPATIO	IN		168	. KIND OF BUS	INESS/IND	USTRY	MILLEC	-
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	work done d se retired.)		st of working	ng								
AP!	12 yrs.	4 yrs.	resid	ident Mercantile B						Bank	& Trus	t		
Ö	17, FATHER'S NAME (First, Middle, Last)									Middle, Maiden				
BE (Joseph L. Rohe								erine Krastel					
5	190. INFORMANT'S NAME (Type/Print) Matthew Rohe		19t	MAILING	ADDRESS	(Street ar	nd Number	r or Rural I	Route Num	Md. 2	n, State, Zip	Code)		
	20a. METHOD OF DISPOSITION							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	1X Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)		Parky		"Ceme	tery	<i>t</i>		20-9		timo			
	21. SIGNATURE OF FUNERAL SERVICE LIC	asseli						uner ir R		ome altimo:	re, M	1d. 2	21236	
	23. PART I. Enter the disesses, of complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abock, or heart failure. List only one cause on each fine. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Betwee Onset and Dasider Cause (Final disease) DUE TO (OR AS A CONSEQUENCE OF):										etwee			
ERTIFICATION	Sequentially flat conditions, If any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated avanta resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):										-			
PHYSICIAN: MEDICAL C	PART ii. Other aignificant condition	a contributing to da	ath but not r	esuiting	in the un	derlying	cause	given in	Part I.	24s. WAS AN PERFOR 1 YES 2	MED?	24b.	WERE AUTOPSY F AMAILABLE PRIOR COMPLETION OF OF DEATH?	CAUSE
Σ.	DID TOBACCO USE CONT	RIBUTE TO CAUS	SE OF DEA	JH Y	ES 🗆 1	40 [1 UNG	CERTAI	N M				1 YES 2	NO
IAN	25. WAS CASE REFERRED TO MEDICAL				TH (Check									
SIC	EXAMINER?	HOSPITAL:	9/Outpatlant 3	□ DOA	OTHER 4 Nun	t: ilng Hom	e 5 🗆 R	lesidence	a Xon	er (Specify)	Но	spi	ce	
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJ (Month, Day, 1		28b. TIR	ME OF JURY	28c. INJI WO 1 Y	RK?	□ NO	28d. DE	SCRIBE HOW I				_
TED BY	2 Accident Investigation 3 Suicide a Could not be determined	28s. PLACE OF IN- building, atc.		me, ferm,	atreet, fact	ory, office	0			CATION (Street of or Town, State)	and Number	or Rural F	Route Number,	
COMPLETED	29a. CERTIFIER (Check only one) 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.													
TO BE CO	296, SIGNATURE AND TITLE OF CERTIFIE	Faul	uen	mo			Sec. LIC	ENSE NU	MBER	3	29d. DAT	E SIGNED	(Month, Day, Year)	
_	20 NAME AND ADDRESS OF DERSON WA	O COMPLETED CAUSE (OF DEATH /ITE	M 270 /5mg	n Drint1							-		

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD.,
NOV2 0 1995 Jah. 3 REGISTRAR'S GNAYURE 21204 TOWSON, MD

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the intending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) Brooks E. Reed										2. DATE OF DEATH DAY YEAR 12 95				
	4. SOCIAL SECURITY NUMB		5. SEX 1 1 1 2 1 F	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER	DAYS	IF UNDER	R 24 HRS. MIN.	7. DATE OF BI	807	Count	HPLACE (State or Foreign by)		
	9s. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CIT	r, TOWN	OR LOCATI	ON OF DE	EATH 9c. COUNTY OF DEAT			DEATH		
E O	Frederick	Heal	th Care	Cente	r	Fr	ede	ric	k		Frederick				
DIRECTOR	RESIDENCE OF DEC	10b. COUNT	v		I in on	EV POMBI	001000						10d. INSIDE CITY		
E	Virginia					Arlington					LIN				
	10e, STREET AND NUMBER	ALLI	ngton		A.	T T T I		. ZIP COD	-		1 40-	1 TYES 2 1 NO			
RA	313 North	roo	nhrier	Stroot											
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 2 3	Married	12. WAS DECEDENT	TEVER IN U.S. AR	N U.S. ARMED 13. WAS DECENDENT OF HISPAN 2 NO If yes, specify Cuben, Mexican								RACE — American Indian, Black, Whits, atc. Specify:		
COMPLETED		EDENT'S EDU highest grade		(G	a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. De NOT use retired.)										
릴	College (1-4 or 5+) Defense Mapping Age:									cy U	.S. G	overr	nment		
ON	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surrame)														
BEC	Morticah	Reed										own			
T0 B	196. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11306 Hessong Bridge Rd Thurmont, 1											.Md 21788			
	20a. METHOD OF DISPOSITION 20a. METHOD OF DISPOSITION 1 DATE 20c. LOCATION - City or Town, State 20c. Location - City														
	21. SIGNATURE OF FUNERAL		22.	NAME A	ND ADDRE	SS OF FAC									
	Julia	Falls Church, Va 22046 73. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximates													
FICATION	shock, Dr heart fellure. List pnly Dne ceuse Dn eech line. Interval Between Onset and Death on resulting in death) Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diesses or injury that intilisted water) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):														
CERTI	resulting in death) LAST														
MEDICAL CERTIFICATION	PART II. Other algnifice	resulting	In the u	nderlyin	g ceuas	given in		WAS AN AUTO PERFORMED? YES 2 MICH		D. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
PHYSICIAN:															
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? Check only one) 1. OTHER:														
X	1 YES 2 NO		1 Inpatient 2 28s. DATE OF		_	_			saldence	6 Other (Spe	**				
ВУ РН	1 🕅 Natural 5 🗌	Pending Investigation	(Month, De	ny, Year)		JURY	1 🗆	YES 2] NO	28d. DESCRIB	E HOW INJUR	Y OCCURED			
		Could not be determined	28s, PLACE Of building,	F INJURY At he atc. (Specify)	eme, farm,	street, fac	tory, offic	•		261. LOCATION City or Tox		imber or Rural	Route Number,		
COMPLETED			ICIAN: To the best of ER: On the besis of sa										s) and manner as stated.		
BE	296. SIGNATURE AND TITLE	OF CERTIFIE	R B, war	el.	0.				ENSE NUM	10ER 3/9/	29d		(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) APTITUDE (1. MANTINO. Mp. 187 Throng Tolong & French 1. Mp. 21702														
	31. DNOVE (Month. 19	95 J		RIS FIGNUALINE											

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within M hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bunal-transit permit. Pages 1, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H			YGIENE EG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) AURORA. I	. 5	ANTO			2. DATE OF D	EATH	SYEAR 3	TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE ((In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day	IRTH	a. BIRTHPL Country)	ACE (State or Foreign					
70R	90. FACILITY NAME (If not institution, give stre Howard County Go RESIDENCE OF DECEDENT		tal	Pb. CITY, TOWN C	La	HITA	тн							
DIRECTOR	10e. STATE 10b. COUNTY	N/A		v, TOWN OR LOCAT					Dd. INSIDE CITY LIMITS? X YES 2 NO					
RAL	10e. STREET AND NUMBER	Toophone		Y	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?							
BY FUNERAL	9 Maalalahanin St 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	N U.S. ARMED	If yes, sp	ENDENT OF HISPAN ecity Cuben, Mexica 2 NO Specify	n, Puerto Ricen	pecify Yes or No-	14. RACE - Black, \ Specify:	opines - American Indian, White, atc.					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		18e. DECEDENT'S (Give kind of v life. Do NOT us	USUAL OCCUPATION Work done during more retired.)	ON st of working	16b. KIN	D OF BUSINESS/IND	USTRY						
MPL	12	4+	Princi	pal			Education	1						
	17. FATHER'S NAME (First, Middle, Last) Alfonse Ionacio				Maria G		e, Maiden Sumame)							
BE (19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street a	Ind Number or Rural	Route Number, C	Otty or Town, State, Zip	Code)Ph.	ilippines					
9	Andres S. Santos, Jr. 9 Maalalahanin St. Teachers Village, Quezon City													
	20s. METHOD OF DISPOSITION 20s. PLACE AND DATE OF DISPOSITION (Name of 1 X) Burlet 2 Cremetion 20s. PLACE AND DATE OF DISPOSITION (Name of 1 X) Burlet 2 Cremetion 20s. LOCATION — City or Town, State 20s. LOCATION — City or Town, State 11/25 Philippines													
	22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk. 5695 Main St., Elkridge, Md. 21227													
	ahock, or Heart failure L.	23. DOT I. Enter the disasses or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition AGUTE MYOCAMPIAC INFARCTION LOVA												
	disease or condition - a. AWTE MYOCAMPIAC INFARETION													
,	DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated evants reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.													
MEDICAL C	PART II. Other algnificent conditions	contributing to deeth b	but not resulting	In the underlyin	g ceuse given in		PERFORMED?	- 6	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
N.	DID TOBACCO USE CONTR	IBUTE TO CAUSE C				NO								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	AG. PLACE OF DEA	TH (Check only one, OTHER:										
HYS	1 PYES 2 NO 27, MANNEB OF DEATH	1 ☐ Inpetient 2 ŒER/Out	28b. TIN	E OF 28c, IN	JURY AT		BE HOW INJURY OC	CURED						
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN.		YES 2 NO									
ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spe		street, factory, offi	ca	28f. LOCATIO City or To	ON (Street and Number own, State)	or Rural Ro	yte Number,					
COMPLET	Front and	CIAN: To the best of my know							and menner as stated,					
BE	296. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER D31473 POOL 18 1995													
0	PATRICE A. TOTE MS 456THEW SILE CREWY Elicate Caly W													
الع	3 NOV 2 0 1995 (See) 32. REGISTRAR'S SIGNATURE													

1 P3 - 0

BALTIMORE, MARYLAND 212 15-020

	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND C	/ DEPAR	TMEN	T OF H	IEALTH DEAT	AND:	MENTA	L HYGIEN			4001
	1. DECEDENT'S NAME (First, Middle, Last)	S-	fottle	20	ye	~			MONT	OF DEATH	AY .	YEAR 795	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 217-03~1911	XX M 2 □ F	6. AGE (In yrs. le	YRS.	MONTHS	DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Mont	of BIRTH h, Day, Year) ber 8,1		8. BIRTH Count	APLACE (State or Foreign ry)
TOR	98. FACILITY NAME (If not institution, give structure) Uhion Mem RESIDENCE OF DECEDENT		Hospit	Fu [B	1.1	m D			Ly	9c. COU	NTY OF D	EATH
L DIRECTOR	10a. STATE 10b. COUNTY Maryland N 10e. STREET AND NUMBER	/A		10c. CITY, TOWN OR LOCATION Baltimore							40 - 077		10d. INSIDE CITY LIMITS? XX YES 2 NO
FUNERAL	700 West 40th St	12. WAS DECEDENT			13	. WAS DEC	2121 2121	F HISPAI	NIC ORIGIN	Y? (Specify Yes		14. BACI	JSA E — American Indien,
В	Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WA	P OR DATES	<u>(</u> 400		If yes, sp	ecify Cube 2 X XNO	n, Mexico	n, Puerto	Rican, atc.)		Spec	k, White, atc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		()	GIVE KIND OF THE PORT OF THE P	work done se retired.,	during mo	st of working	g	166	N/		DUSTRY	
BE COM	17. FATHER'S NAME (First, Middle, Last) Charles Stottlen	ıyer			- I W	OTIC	18. MOTI		ME (First, I	Middle, Maiden			
0	190. INFORMANT'S NAME (Type/Print) Keswick Home									imore,			1 21211
	Keswick Home 700 West 40th Street Baltimore, Maryland 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town congelecy, crequatory or other place) 20b. PLACE AND DATE of DISPOSITION Name of congelecy, crequatory or other place) 20b. PLACE AND DATE of DISPOSITION Name of congelecy, crequatory or other place) 20b. PLACE AND DATE 20c. LOCATION — City or Town or other place) 21b. PLACE AND DATE 20c. LOCATION — City or Town or other place) 21c. NAME AND ADDRESS OF FACILITY										wn, stete laryland		
	Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 23. PART I. Enter the disease of or complications that caused the death, Do not enter the mode of dying such as cardiac or respiratory expent.												
	23. PART I. Enter the diseases or compligations that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel											Approximate Interval Between Onset and Death	
z	resulting In death) s. Card(oful monory arrest DUE TO (OR AS A CONSEQUENCE OF): Sepsis: Systemic in lation 9											230minu	
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Flyrs.		
	PART II. Other significent conditions	contributing to d	leeth but not	resulting	In the u	nderiyin	ceuse g	lven in	Part I.	24a. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS
MEDIC/	Nove				-				_	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ATH YE		only one)	UNC	ERTAII	Ν□				
BY PHYS	1 YES 2 No. 1 Minpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 Netural 5 Pending												
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF building, et	INJURY — At h	ome, farm, s	street, fed	tory, offic			28f. LOC City	ATION (Street of or Town, State)	nd Number	or Rural F	loute Number,
COMPLETED	29a. CERTIFIER (Check only one) 1												
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Da	PGY	0.7			29c. LICE		MBER 946	,	29d. DATI	E SIGNED	(Month, Day, Year)

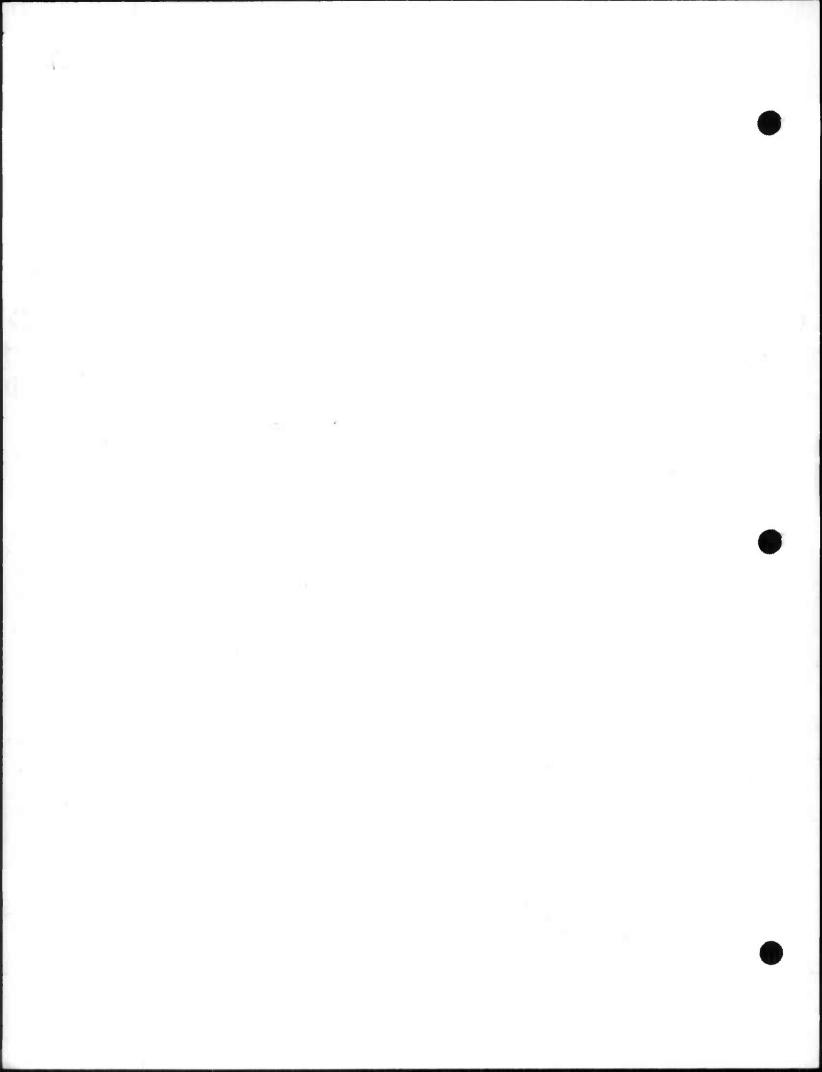
UNION

MEMORIAL

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DANY SHAN 31. DNOV 2 0 1995

HOSP.



altransit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TS hours after death. Page 6 may be retained by the hospital of THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: It liem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND

DIVISION OF VITAL RECORDS, P.O. BOX 68769

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N	MENTAL	HYGIEN
CERTIFICATE OF DEATH		BEG NO

	FOR STATE REGISTRAR	STATE OF MAP	YLAN	D / DEPAR	TMEN'	T OF H	EALTH A	AND MI		IYGIENE BEG. NO.				
	1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH		3. TIME OF	DEATH	
	Dorothy	Shaeffer						N	MONTH IOVEMI	per 18	. 1995	7:1.	3 P	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. /	GE (In yn	s. last birthday)	IF UNDER		IF UNDER 24	4 HRS. 7	7. OATE OF I	BIRTH	8. BIRT	THPLACE (State		
	217 21 1333	I □ M 2 🔀 F	80	YRS.	MONTHS	DAYS	HOURS	MIN.		0, 1915		country) ennsylvinia		
	9s. FACILITY NAME (If not institution, give street	et and number)			9b. CITY	, TOWN	R LOCATION				COUNTY OF		*****	
DIRECTOR	GREATER BALTIMOR	E MEDICAL	CE	INTER		WSON					BALTI	MORE		
IRE	Maryland Baltin				Y, TOWN		ION					CITY		
	Maryland Baltir	llore			Anne	_						1 TYES	-	
FUNERAL	616 Overbrook Roa	d				101	. ZIP CODE	212		101		WHAT COUNTS	YY?	
Z I	616 Overbrook Road 21212 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No											.A.		
	1 Never Married 2 Married	FORCES? 1 1 1				If yes, sp	ecify Cuban,	Maxican,	Puerto Rica	n, atc.)	Bia	CE — American ck, White, atc.	Indian,	
ВУ	3 X Widowed 4 Divorced	IF TES, GIVE WAY, C	n DATES			1 L YES	2X NO	Specify:			Spe	Whit	0	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION moleted)	.16a	DECEDENT'S					16b. KIN	ID OF BUSINES	SS/INDUSTRY	WILL		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	\dashv	(Give kind of v	e retired.)	-	st or working							
MP	12 years			Homer	nakei	r				Own Ho	me			
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAME	(First, Middl	le, Meiden Sumi	ame)			
BE		vert					Mary				Elwee			
2	19e. INFORMANT'S NAME (Type/Print)									City or Town, Sta				
	Alan Willson			422 8	5. Sa	an Ma	arino	Ave	. Pas	adena,	Calif	ornia	91107	
	20e, METHOD OF DISPOSITION 1 \(\text{L} \) Burial 2 \(\text{L} \) Cremation 3 \(\text{L} \) Remove	I from State	20b. PLA	CE AND DATE	or DISPOS	ITION (Na	me of		OATE		DN — City or 1			
	4 Donation 6 Other (Speedly) Moreland Memorial Park 11/22 Baltimore, Maryland													
	22. NAME AND AGORESS OF FACILITY Mitchell—Wiedefeld Home													
	Serre / Fe	nane									Marral	and 21	21.2	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arreat, shock, or haert failure. List only one cause on each line.												ximsta al Between	
	IMMEDIATE CAUSE (Fine) disease or condition												and Death	
	resulting in death)											110	ech	
_ 1	DUE TO (OR AS A CONSEQUENCE OF):													
<u></u>	Sequentially liat conditions, Due to (or as a consequence of):													
¥	If any, leading to immediate cause. Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or injury that initiated events Due TO (OR AS A CONSEQUENCE OF):													
R	resulting in death) LAST													
	PART II. Other algolificent conditions of	contributing to desi	b but a	et enculting l	- Ab									
CAL	4.1 /4.1	live	ii but ii	or resulting i	n the un	cerrying	cause giv	ven in Pa		PERFORMED	?	b. WERE AUTOP: AVAILABLE PF	IOR TO	
	- Trace of all								_ 10	YES 2	10	OF DEATH?	OF CAUSE	
Σ	DID TORACCO USE CONTRU	NITE TO CAUC	05.0	FATIL VE	<u> </u>				_			1 [] YES 2	□ NO	
A N	DID TOBACCO USE CONTRIE	BUTE TO CAUSE		LACE OF OEAT			UNCE	RIAIN						
PHYSICIAN: MEDIC	CVARRIEDO	OSPITAL:			OTHER	₹:								
¥ ∥	27. MANNER OF DEATH	inpetient 2 - ER/		26b. TiM			5 Real							
	1 Natural 5 Pending	(Month, Day, Ye	nr)	INJ		28c. INJE	RK?		ed. DESCHII	BE HOW INJUR	Y OCCUREO			
B	2 Accident investigation 3 Suicide & Could sal be	26a. PLACE OF INJ	JRY — A	t home farm s	treet fact				ef LOCATIO	N (Street and Ni	water or Burst	De de Musebas		
윤	4 Homicide 6 Could not be determined	building, atc. (Specify)			o.y, o.ne		"	City or To	wn, State)	umber or nore:	rioute Number,		
9	29a. CERTIFIER				_				_		_			
COMPLETED	(Check only one) CERTIFYING PHYSICIA CERTIFYING PHYSICIA CERTIFYING PHYSICIA													
양∥		on the seaso of gazanini	mon and	Por investigation	n, in my o	pinion, a	atn occurse	at the tim	ne, data and	place, and due	to the cause	a) and manner	as stated.	
8	29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Morgh, Day, Year) 29c. LICENSE NUMBER 29d. DATE SIGNED (Morgh, Day, Year)													
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 (Tex Origin)													
	David D. Collins MD, 3333 N. Calvert St., Shite 560, BALTO, MD													
	31. NUV 2 0 1995 Falls delivered and the deliver													

th. Page 6 may be retained by the hospital or attending physician,	neral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should		miner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

										90	3495) 9	
	1 - STATE REGISTRAR	STATE OF M			TMENT OF H	EALTH AND I	MENTAL	HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF DEATH	W	YEAR 3	3. TIME OF DEATH	1	
	Julia E	lla			SAUTER					1995	2:30	a M	
	4. SOCIAL SECURITY NUMBER 5.	SEX	6. AGE (In yrs. last		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		6. BIRTHPL	LACE (State or Fore		
	217 01 2113	□ M XX F	85	YRS.	MONTHS DAYS	HOURS MIN.	Dec	. Day, Year)			lland		
~	Sa. FACILITY NAME (If not institution, give street					OR LOCATION OF O	EATH		9c. COU	NTY OF OEA	TH		
Ö l	Franklin Square Ho	speud			Roz	ssville			Ва	1timo	re		
DIRECTOR	10a. STATE 10b. COUNTY	Baltimo,	ie.	10c. CIT	, TOWN OR LOCAT	TION ESS	ex				INSIDE CITY LIMITS?	NO	
FUNERAL	100. STREET AND NUMBER 912 Thompson Blud	•			100	. ZIP CODE				States			
S S	11. MARITAL STATUS 12. 1 Never Married 2 Married		EVER IN U.S. ARI			ENDENT OF HISPAI			or No-	14. RACE - Black,	- American India: White, atc.	n,	
ΒX	3 X Widowed 4 Divorced	IF YES, GIVE WA				2 X NO Specif				Specify:	white		
	15. DECEDENT'S EDUCATION				USUAL OCCUPATION		18b.	KIND OF BU	SINESS/INC	DUSTRY	Wilde		
ᇤ	(Specify only highest grade com Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	Do NOT us		st of working								
N P	8 Years			Hous	ewife			Ou	in Hoi	ne			
BE COMPLETED	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surname) Annie Soeder												
0 8	19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
-	Dorothy J. Smith 912 Thompson Blud. Essex, Maryland 21221 20B. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Date 20c. LOCATION - City or Town, State												
	20s. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State				corp. 11/	18/9	5 20c. LO	OWSO	n. Ma	n, State ruland		
	21. SIGNATURE OF JUNEAU SERVICE LICENS	1	, I much	op s									
	· Chal W.	tin			7922	Ruck Fur Wise Au	ieral 2. D	Home undalk	of D	unaak 212	22 Inc.		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one cause on each line.												
	IMMEDIATE CAUSE (Final											Death	
	disease or condition reaulting in death) - Cardiogenic shock											es	
	DUE TO (OR AS A CONSEQUENCE OF):												
N N	Sequentially list conditions, Myocardial infarction Due to (or as a consequence of):											r	
AŢ.	If any, leeding to immediate cause. Enter UNDERLYING	Hypert		UENCE U	r):								
<u> </u>	CAUSE (Disease or Injury C. —	W 1	OR AS A CONSEC	LIENCE O	R)+						years		
CERTIFICATION	that initiated events resulting in death) LAST		ry hear		,						vears		
2													
PHYSICIAN: MEDICAL	PART II. Other significent conditions of Partial com			esulting	in the underlyin	g cause given in	Part 1.	24a. WAS AN PERFOI 1 YES 2	RMED?	1 6	WERE AUTOPSY FIN NVAILABLE PRIOR T COMPLETION OF C DF DEATH?	го	
ME	DID TOBACCO USE CONTRIB	LITE TO CAL	ISE OF DEA	TII VI	S D NO 5	LINICEDTAL				1	T YES 2 N	Ю	
AN	25. WAS CASE REFERRED TO MEDICAL	OTE TO CAL			TH (Check only one)	UNCERTAI	ΝЦ						
SIC	EXAMINER?	OSPITAL:	ER/Outpatient 3		OTHER:	ne 5 🗆 Raeldenca	4 D Other	# (Specific)					
H	27. MANNER OF DEATH	28a. OATE OF	INJURY	28b. TIN		JURY AT		CRIBE HOW	NJURY OC	CUREO			
	1 X Netural 5 Pending (Month, Day, Year) INJURY WORK? M 1 YES 2 NO												
ED BY	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide detarmined		INJURY — At ho	me, ferm,	street, factory, offic	a		ATION (Street or Town, State)		r or Rural Ro	ute Number,		
	29a. CERTIFIER	No To at the state of	- to a to a	-41-									
COMPLETED	C(Check only one) 2 I CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, deta and piecs, and due to the cause(a) and manner as stated. 2 I MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piecs, and due to the cause(a) and manner as stated.												
	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NU					Month, Day, Year)		
BE		ntoni	no n			D460			DAIL DAI	11/17	1 9 5		
ဥ	· · · /////// / _ //	0-00	11111			- 100	V 1		1 '	11/1/	110 .		

Marie Bellantoni, M.D. 9101

31. DATE FILED (Month, O. 1995)

32. DEGISTRAR'S STATURE

NOV 2 0 1995 9101 Franklin Square Drive Baltimore, MD 21237

		1 - FOR STATE REGISTRAR	STATE OF MARYL	ND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAI	L HYGIENE						
		1. OECEDENT'S NAME (First, Middle, Lest)	a				2. DATE	OF OEATH			ME OF DEATH			
		blanche.	Sauers	Blanche	E. Saue:	rs	1 77	15	- 9	S	1.54 P M			
	- 1			n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH	8	. BIRTHPLAC	E (State or Foreign			
2		210 32 0010	1 🗆 M 2 🔀 F	88 YRS.	MONTHS DAYS	HOURS MIN.		/1907	τ	inknow.	n			
1		9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOWN	OR LOCATION OF C			9c. COUNT	Y OF DEATH				
MC	É	Trinity Nursing Ho	me		Wood	lawn			Balti	more				
(Wall	DIRECT	10a. STATE 10b. COUNTY		10c. Ci7	Y, TOWN OR LOCA	TION					INSIDE CITY LIMITS?			
H H		Maryland Balti	more	7	Voodlawn						YES 2 X NO			
De la	FUNERAL	10e. STREET AND NUMBER				f, ZIP CODE			10g. CITIZE	N OF WHAT	COUNTRY?			
020 physician. burial-transit	빌	7600 Clays Lane				21207			USA					
20 Tysic	윤	11. MARITAL STATUS 1 ▼ Never Merried 2 Married	2. WAS OECEDENT EVER IN FORCES? 1 YES	2 VNO	13. WAS OED	ENDENT OF HISPA ecify Cuban, Maxic	NIC ORIGIN	? (Specify Yes o	or No — 1	4. RACE - Ar Black, White	merican indian, la. etc.			
0 5 5 9 9	B	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	TES A		NO Speci		W11244 23114		Specify:				
215-0020 attending physician. se as the burial-trar	ED	15. DECEDENT'S EOUCA	TION	16a OFCEDENT'S	USUAL OCCUPATION	ON	404	KIND OF BUSI	1	_	hite			
		(Specify only highest grade co		(Give kind of life. Do NOT u	work done during mo	ost of working	160.	KIND OF BUSH	NESS/INDU:	STRY				
the hospital or detached for u	립	Unknown	Consign (I-4 til 5 +)	r	Never Wo	rkod		N/A						
AND the hospita detached detached once.	E COMPL	17. FATHER'S NAME (First, Middle, Last)			VEVEL WO	18. MOTHER'S N.	AME (First. A		urneme)					
# E E		Unknown				Unkn		moore, margeri or	57712770)					
MAR retained 5 should notified	00	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a			ner City or Town	State Zin C	odel				
5 5 5	임	Trinity Nursing Ho	me		Clays Lar									
MORE, age 6 may be director, page		20a. METHOD OF DISPOSITION	20h.		OF DISPOSITION (No		OATE			y or Town, St	lete.			
e 6 ma ector, p		1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	if from State HO.	ery, crematory or o	y Cemete	erv	11/				aryland			
Page 6 al directo		21. SIGNATURE OF FUNERAL SERVICE MOS		7	22. NAME AI	ND ADDRESS OF FA	ACILITY			IC, I'm	ALYLANA			
ALTIN death. Pag e funeral dir i. examiner		502 -V/	12/	2	David	J. Webe	r Fun	eral H	Ome					
	\vdash	22 PART I Enter the diseases of the	11196		[401 S.	. Cheste	r St.	Baltı	more,	Md.	21231			
nours after ed in by th or remove		23. PART i. Enter the diseeses, of cor shock, or heart failure. Lit	it only one cause on ea	ch line.	not enter the mo	de of dying, suc	ch se card	lac or respire	itory arres	it,	Approximate interval Between			
filled ion, c		IMMEDIATE CAUSE (Final disease or condition												
760, ed within ompletely il, cremat event, 1	ı	resulting in death)		3408.										
				1	()									
OX 68 e be execut sician and o nior to buni	CATION	Sequentielly list conditions, b.												
siciar be be trau	AT	if any, leading to immediate cause. Enter UNDERLYING			,			į						
ertifical ing phy rgiene	RTIFIG	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):									
ending P. C	F	resulting in desth) LAST								!				
deal deal deal ternta	CE	PART II Other classificant conditions	and the state of t							+				
wand by the N	AL.	PART II. Other algnificent conditions	contributing to death bu	not resulting	in the underlying	g cause given in	Part I.	24a. WAS AN AT PERFORM			AUTOPSY FINDINGS ABLE PRIOR TO			
2 5 5 E	EDIC/	- Allegan	albara					1 TES 2	NO		PLETION OF CAUSE EATH?			
w requires been signed to the afternation of Health shows a	Σ	Metilar	Kelono	dalle	on:) A				10	YES 2 NO			
law law ept.	ÿ	Diabele	o Die	A CO	ulla	lled								
를 함을 를	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		28. PL	ACE OF OEATH (CI	heck only one	9)						
PHYSICIAN: The this certificate with the State riked, or Item	YS	1 YES 2 NO	☐ Inpatient 2 ☐ ER/Outpe		4 Nursing Hom	e 5 🗆 Rasidence	8 🗆 Other	(Specify)						
NG PHYSI fler this coath with marked,		27. MANNER OF DEATH 1. Natural 5 Pending	(Month, Day, Year)	28b. TIM	URY WO	RK?	28d, DE\$	CRIBE HOW INJ	IURY OCCUI	RED				
After death	B	2 Accident Investigation	20 - Pl ACE OF IN HIM			YES 2 NO								
OR ATTENDING DIRECTOR: After ours after death	9	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, atc. (Specif	— At home, farm, :	street, factory, offic	9	281. LOCA	ATION (Street and or Town, State)	d Number or	Rural Route N	lumber,			
OR ATTENI DIRECTOR: hours after item 28 is	COMPLET	an oranicis												
3 3 2 5	릴	29a. CERTIFIER (Check only one)												
HDSPITAL FUNERAL within 72 TANT: If	į	2 MEDICAL EXAMINER:	On the basis of exemination	and/or investigation	n, in my opinion, d	eath occured at the	time, data	and place, and	due to the o	ause(a) and r	nenner sa stated.			
HE HE M	ш	296. SIGNATURE AND TITLE OF CERTIFIER	^'			29c. LICENSE NU	MBER		29d. DATE S	IGNED (Month	n, Day, Ybar)			
TO THE HOSPIT TO THE FUNERA De filed within 7	TO B	1. Fall	▶ 1 (16 9	5									
	-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type	Print) Old	Corne	RO	1 Ka	udo	llst.	QUA.			
		1AHOOKA 1	A WAJA		0 010			402	113	3	-un			
		NOV 2 () 1995	32, REGISTRAR'S SIGNA	TURE										
		NUV 2 0 1995 Jul	A diluderile	LH										

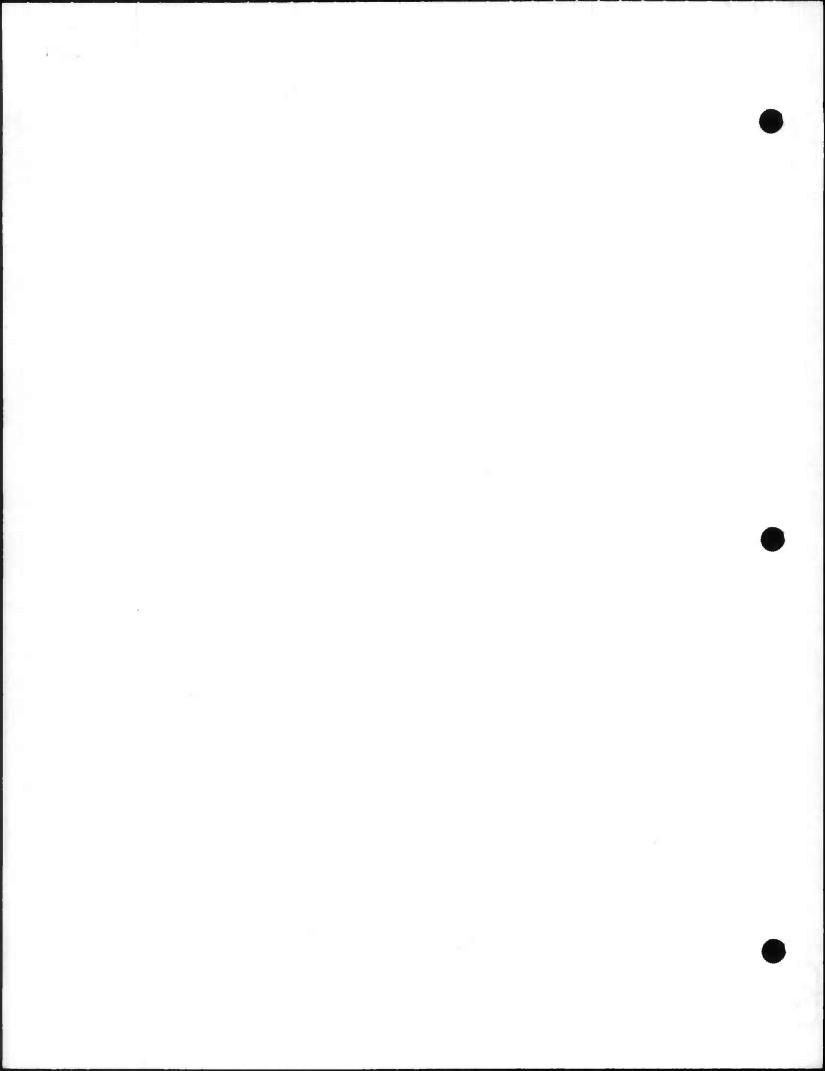
U.S.

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FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF) / DEPAF CERTIF					IENTAL HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (First, Mile	oldle, Last)							2. DATE OF DEATH			3. TIME OF DEATH
1	George J.	Siemek						r	November '	16, 1	995	10:00 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs	. last birthday)	IF UNDER	-	F UNDER 24	HRS.	7. DATE OF BIRTH (Month, Day, Year)			PLACE (State or Foreign
	218-12-0150	1 1 M 2 □ F	72	YRS.	MUNITES	DATS H	ouns	MIN.	02/21/23		Mary.	
-	9a. FACILITY NAME (If not institu					TOWN OR L		OF DEA	ATH	9c. COU	INTY OF D	
DIRECTOR	1823 Fleet St				Ba	altim	ore				N	/A
<u> </u>		b. COUNTY		10c, CIT	Y, TOWN O	R LOCATION	-					10d. INSIDE CITY
10	Maryland	N/A		Baltimore								LIMITS?
A	10e. STREET AND NUMBER					101. ZII	P CODE			10g. CIT	IZEN OF W	THAT COUNTRY?
E	1823 Fleet St	reet				21:	231			USA	1	
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Mar	12. WAS DECEDE FORCES?	NT EYER IN U.S.	ARMED NO	13. V	AS DECENE	DENT OF	HISPANI	C ORIGIN? (Specify Ye., Puerto Rican, etc.)	s or No—	14. RACE	- American Indian, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE	WAR OR DATES			YES 2			, route mean, etc.)		Specif	Transfeller -
ED	15. DECEDE	ENT'S EDUCATION		DECEDENT'S	USUAL OC	CUPATION			16b. KIND OF BU	CINECO (MI	OLIGITAV	WIICE
E	(Specify only hig Elementary/Secondary (0-12)	(hest grade completed) College (1-4 or 5		(Give kind of a life. Do NOT us	work done d	uring most of	f working		loa. Idilo di Bo	3111233/111	OOJINI	
P.	12th			Food S	tore	Owne:	r		Retai:	l Foo	od	
COMPLET	17. FATHER'S NAME (First, Middle	e, Lest)						R'S NAM	E (First, Middle, Maiden			
BE (Joseph Sieme					[ırek		
2	19a. INFORMANT'S NAME (Type/	*							oute Number, City or Tow			20100
	Diane S. Mors							ace	Vienna, V			
	20a. METHOD OF DISPOSITION 1V Burlet 2 Cremation 4 Donation 6 Other (Sp.	3 Ramoval from State	20b. PLA cemetery,	ceand dated crematory or o y Rosa	of DISPOSI ther place)	FION (Nama	of		1		City or To	
	21. SIGNATIME OF FUNERAL SE		_ HOT	y ROSa	22. N	AME AND A	DORESS	OF FACI	11/18 Ba.		re,	Maryrand
	400 .	UMBA	′	_	9				Funeral 1			24.224
\vdash	23. PART I. Enter the dise	sea, or complications th	st caused the	death. Do r	140	ha mode	ches	ter	St. Balt:	LMOre	e, Ma	
	anock, or near	t failure. List only one co	use on each l	line.			or dynng	, 40011	as cordiac or resp	ii atory ar	rest,	Approximate Interval Between Onset and Death
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. a	Cute 1	Muora	Nov 16, 1995							
	readiting in death)							000	V1	01-1-		
Z	Sequentially list conditions	Ch	mortyp	Hyper Housiam V								1919186.
CERTIFICATION	If any, laeding to immediat cause. Enter UNDERLYING	le DOE II	o (OR AS A JOHN								9/0/81	
윤	CAUSE (Disease or Injury thet initiated events		O (OR AS A CON									1100.
	resulting in death) LAST	1			,							
	DADT II Other leading	u.										
CAL	PART II. Other significent of	conditions contributing t	o death but no	ot recuiting i	in the unc	lerlying ce	ouse give	en in P	art I. 24e. WAS AN PERFOR			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDIC									1 YES 2	Ao		COMPLETION OF CAUSE OF GEATH?
Σ	DID TORACCO LICE	CONTRIBUTE TO C	AUGE OF D	EATH NE	c [7]				-/			1 TYES 2 NO
AN	DID TOBACCO USE 25. WAS CASE REFERRED TO-MI			LACE OF DEAT			UNCER	CIAIN	(X)			1 1 1 1
PHYSICIAN:	EXAMINER?	HOSPITAL: 1 ☐ Inpetient 2			OTHER		· Sould		Other (Specify)			
¥	27. MANNER OF DEATH	26a. DATE O	F INJURY	26b. TIM	E OF	28c. INJURY	AT		28d. DESCRIBE HOW I	NJURY OC	CURED	
ВУ Р	1 Natural 5 Peni 2 Accident Inve	ding (Month,	Day, Year)	INJ	URY M	WORK?		10				
	3 Suicide 6 Cou	28a. PLACE	OF INJURY — At	home, farm, s	treet, facto	ry, offica		1	281. LOCATION (Street a		r or Rural R	oute Number,
11	4 Homicide dete	rmined						- 1	ony or rown, State)			
COMPLETED	29a. CERTIFIER (Check only	ING PHYSICIAN: To the best of	of my knowledge,	death occurre	d at the tin	ne, dete and	placa, an	d due to	the cause(a) and mar	nner aa ste	ted.	
O.	one) 2 MEDICAL	EXAMINER: On the basis of	examination and/	or investigation	n, in my op	inion, death	occured	at the ti	me, deta and place, an	d due to th	na cause(a)	and menner as stated.
BE C	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)											(Month, Day, Year)
10 B		g amon	-					26!		•	17 17	195
	30. NAME AND ADDRESS OF PE	RSON WHO COMPLETED CAN	SE OF DEATH (TEM 27) (Type,	LOCH?	RAVE	NE	3LV/) BALTIM	ORE	MDE	21239
	31. DATE FILED (Month, Day, Year)		AR'S SIGNATUR					-	100			
	programme, pray, rour)	, se neula in	MU IAMBIE C	_								
	NUV 2 0 1995	1.1: M. 3	P.JH									ļ





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

4	
1	
	Specific (
/	
	ages.

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

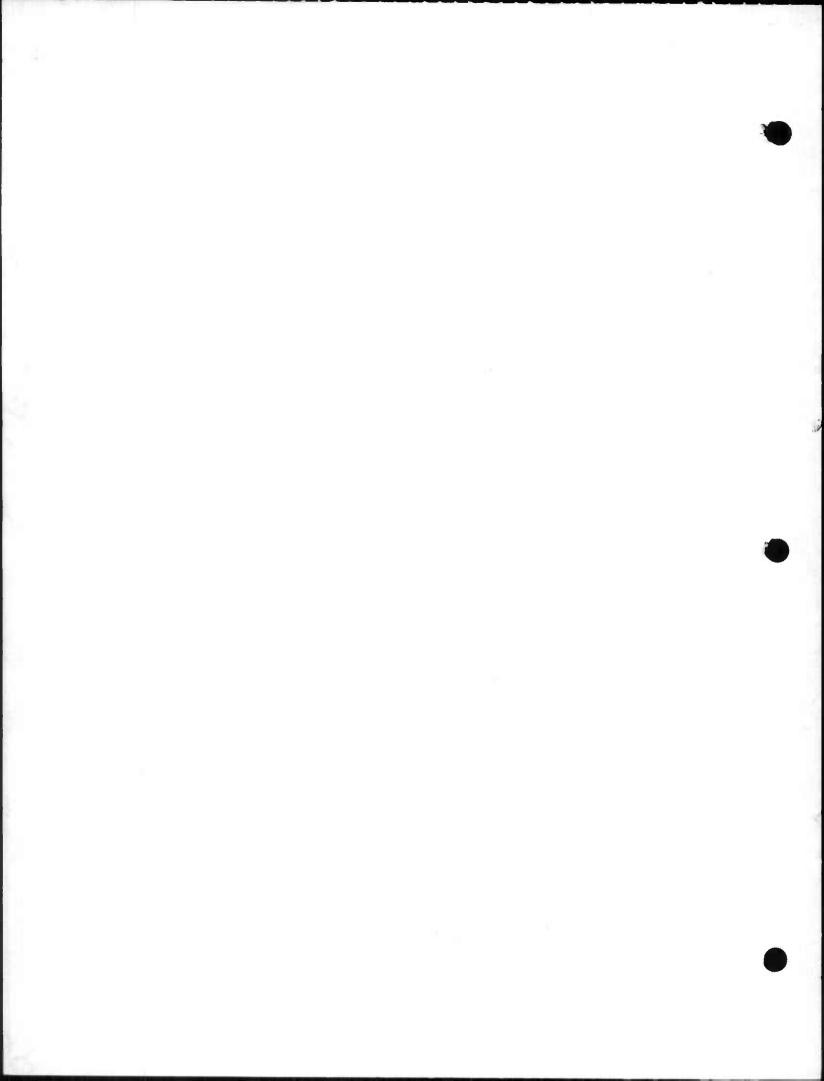
TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1. DECEDENT'S NAME (First,	Middle, Last)	-							2. DATE OF C			меля	3. TIME OF DEATH
	M	YRTLE	SAUND	ERS						NOV.	18	, 19	995	10;45Am
	4. SOCIAL SECURITY NUME		5. SEX	5. AGE (in yrs. i	iast birthday)	IF UNDER		_		7. DATE OF BIRTH (Month, Day, Year)				IPLACE (State or Foreign
	213-14-320	01	1 🗆 M 2 💢 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	JULY 29		. 1907 M/		MARYLAND
	9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY	Y, TOWN	OR LOCATI	ON OF OR			9c. COUN		EATH
OR	1617 E. PI		N ST.				BAL	TO,	CIT	Y				
5	RESIDENCE OF DEC	10b. COUNTY	,		10c CIT	Y, TOWN	OR LOC	ATION						10d. INSIDE CITY
DIRECTOR	MARYLAND		N/A			,		TO,	CIT	Y		LIMITS? YES 2 NO		
AL	10e. STREET AND NUMBER						1	101. ZIP COD					WHAT COUNTRY?	
FUNERAL	1617 E. 1	PREST	ON STRE	ET					212	13		U	.S.	Α.
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED INO	13.	WAS O	ECENDENT (OF HISPAI	NIC ORIGIN? (S	pecify Yas	or No-	Blac	E — American Indian, k, White, etc.
B≺	1 Never Married 2 3 Nidowed 4 Divo	ξ			ES 2 NO			,		Spec	BLACK			
COMPLETED	15. DEC (Specify onl)	OECEDENT'S (Give kind of	work done	during i	TION most of worki	ng	16b, KIN	D OF BUS	HNESS/IND					
9	Elementary/Secondary (6)-12)	College (1-4 or 5	+)	DOME							ONE		500
M	9TH 17. FATHER'S NAME (First, M	Uddle (not)	N/A		DOME	211		40 1407	WED'C NA	ME (First, Middl				
			BOWMAN							BUTL		Sumame)		
BE	19a, INFORMANT'S NAME (DOMININ		19b MAILING	ADDRES	S (Stree			Route Number, (n State Zin	Code)	
2		JOHN	SON					AND						21216
	20a. METHOD OF DISPOSIT 5∑Burial 2 ☐ Crematic		oval from State		E AND DATE					DATE		CATION —		
	ABBUTUS MEM. PK. NOV. 25, L995 BALTO, MD.													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO.MD.21213													
	23. PART I. Enter the d		nomplications th	my	100	not ente	141	Z E.	PR	ESTON	ST.	BA	LTO	MD 21213
			List only one ca			not ante	to fied a	noda or uj	my, suc	ir ee cerdiec	or respi	ratory or	oot,	intarval Between
	IMMEDIATE CAUSE (Final										Onset and Death			
	and the state of t													
			MW	hble	1/10	W -	ho	elin	9	de	no	iti		24%
CERTIFICATION	Sequentially list conditions,													
AT	If any, lesding to imma csuse. Enter UNDERLY	ING		· ·										
IF	CAUSE (Disease or injuthst initiated events	ury	DUE TO	(OR AS A CONS	SEOUENCE C	F):								
H	resulting in death) LAS	T	d,											
	PART II. Other algolific	ant condition	na annielburilan i	and on the best or a	é considéra	In the se	and a sla		alman In	Bort I D	. 1440 414	ALIPORAN		. WERE AUTOPSY FINDINGS
EDICAL			nemia					ition			PERFOR	RMED? AMILABLE PRI		AVAILABLE PRIOR TO COMPLETION OF CAUSE
D	3		is da		100	O(VV	-	() ,		- 11	YES 2	NO		OF DEATH?
Σ								=						1 - YES 2 - NO
PHYSICIAN:	DID TOBACCO U		RIBUTE TO CA						CERTAI	иП				
C	25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HOSPITAL:	26. Pt	ACE OF DEA	OTHE	<u> </u>	ne)						
YSI	1 TYES 2 NO		1 Inpetient 2		,	4 🗆 Nu	ursing H		tasidenca	6 Other (S				
	27. MANNER OF DEATH	Pending	28e. DATE O (Month,	FINJURY Day, Year)	28b. Til	ME OF JURY		WORK?		28d. DESCRI	BE HOW I	NJURY OC	CURED	
ВУ	2 Accident	Investigation	00 - DI 10F	OF IN HIDY A.	<u> </u>			YES 2	NO		DAI 00- 1			Route Number,
COMPLETED	3 Suicide 6 4 Homicide	Could not be determined	OF INJURY — At , etc. (Specify)	nome, tarm,	street, 18-	стогу, о	THE			own, State)		r or Hunai	Houte Number,	
Ë	29a. CERTIFIER 1 N CER	TIFYING PHYS	ICIAN: To the best of	f my knowledge	death occur	red at the	time d	iste and plac	e and du	a in the cause(a) and ma	nner ee ele	ted	
ME	Check brily	V 100												a) and menner ea stated.
	29b. SIGNATURE AND TITL	F OF CERTIFIE	R					290 110	CENSE NU	IMRER		29d DAT	E SIGNE	D (Month Day Year)
BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 298. AT 54.											0-95		
5	D-38754. D11-20-95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) MALIKA WASEEM., 100. N. BROADWAY, BALTIMORE, MD-21231.													
	31. NOV 2 0 1995 Feb 32 1995 F													
	NOV 2 0 19	195 🤌	and and	OL A MARIA	•									

OHMH-16 Rev 1/89



1	11		S should
	JA	2	permit Room
	0050	physician.	burial-transit
	P	ing	the the

BALTIMORE, MARYLAND 21215retained by the hospital or attendi funeral director, page 5 should be detached for notified hours after death. Page 6 may be red in by the funeral director, page 5 or removal. pe medical completely filled in by I cremation, or DIVISION OF VITAL RECORDS, P.O. BOX 68760 The law requires that the death certificate be executed n and com to burial, o traumatic attending physician a other 0 the after by any signed Health a Shows t. of h has be Dept. 23 certificate h Hem HOSPITAL OR ATTENDING PHYSICIAN: this c marked, After DIRECTOR: At hours after de item 28 is r hours Hem TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho

Dace.

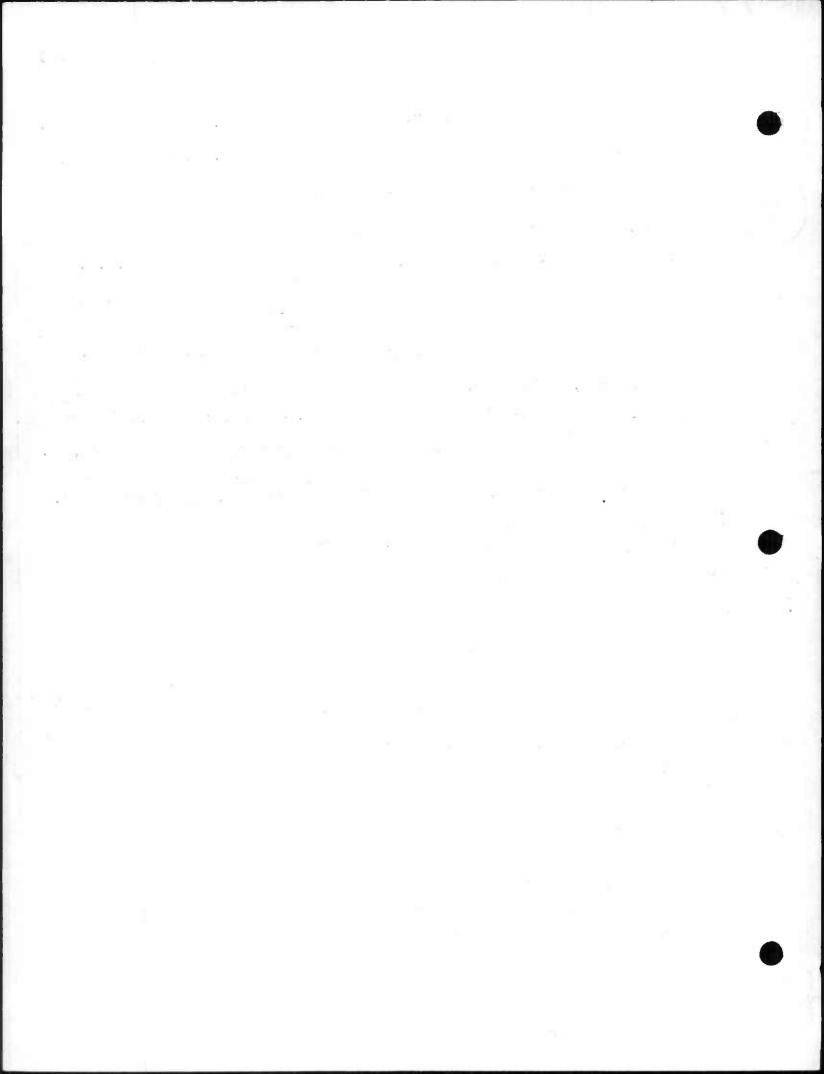
must

examiner

event.

1. DECEDENT'S NAME (First, Middle, Last) Ledgar Walter Smith, Jr. 2. DATE OF OEATH 3. TIME OF GEATH Nov. 19 1995 6 a. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR R. RIFITHPLACE (State or Foreign IF UNDER 24 HRS. 215-12-8088 Apr. 16, 1923 1 XM 2 - F 72 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH 4920 Crossroad-Schoolhouse Rd. DIRECTOR Millers Carroll 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Md . Carroll Millers 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4920 Crossroad-Schoolhouse Rd. 21107 U.S.A. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 Tyes 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY so White 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high 10 College (1-4 or 5+) Vice-President Automobile Co. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edgar W. Smith, Sr. Katherine Hobbs BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Catherine Zuna-Smith 4920 Crossroad-Schoolhouse Rd., Millers, Md 20a METHOD OF DISPOSITION
1 Buriel 2 Cremetton 3 Removat from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE McKendree Cemetery 11/22/95 West Friendship, Md. 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
Eckhardt Funeral Chapel 21, SIGNATURE OF FUNERAL-SERVICE LICENSEE 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heard Manchester ehock, or heert fellure. Liet only one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition MEPATIC FAILURE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CIMMHOSIS CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO X UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 | Inpetiant 2 | ER/Oulpetiant 3 | DOA 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28b. TIME OF INJURY 26a. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 1 YES 2 NO BY Investigation 26a. PLACE OF INJURY — Al home, larm, street, factory, offica building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 🔲 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the lime, date and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, deeth occurred at the time, data and placa, and due to the cause(a) and menner as stated. TITLE OF 29b. SIGNATURE AT 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Qay, Year) 019914 20/90 0 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2324 WJUPPA 21097 no LUTHENVILLE Mb Mb 32 FEET PARTS AND AFTER



t permit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR					- 01	- 01061
1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTME CERTIFICA	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN REG. NO.	E 9:	5 34964
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA	Y YEAI	3. TIME OF DEATH
T.O.L.I.I.D.	A TI	HOMAS	JR.	NOV. 16		
		MONTH	DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Co	RTHPLACE (State or Foreign untry)
	M 2 F 1	9 YAS.		SEPT. 14		MARYLAND
9a. FACILITY NAME (If not institution, give street		-	ITY, TOWN OR LOCATION OF I	CITY	9c. COUNTY O	
RESIDENCE OF DECEDENT	OSPITAL		BALTIMORE	CITI	N/A	
MARYLAND 10b. COUNTY N	/A		N OR LOCATION BALTIMORE	CITY		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
100. STREET AND NUMBER 1509 E. NORTH A	7ENIIE		10f, ZIP CODE	213	10g. CITIZEN O	F WHAT COUNTRY?
	. WAS DECEDENT EVER IN U.	e ADMED	13. WAS DECENDENT OF HISPA			
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, specify Cuban, Maxk 1 YES 2 NO Spec	an, Puarto Rican, etc.)	B	ACE — American Indian, lack, White, atc. pecify: black
15. DECEDENT'S EDUCATI (Specify only highest grade corr		Se. DECEDENT'S USUAL (Give kind of work do	ne during most of working	16b. KIND OF BUS	INESS/INDUSTR	Y
10TH N	ollege (1-4 or 5+) /A	N/A	d.)		NONE	
17. FATHER'S NAME (First, Middle, Last) RONALD THOMAS S	R.			AME (First, Middle, Maiden AUDREY	TAYLOR	
19a. INFORMANT'S NAME (Type/Print) AUDREY THOMAS		196. MAILING ADDR 1509 E.	SSS (Street and Number or Rura NORTH AVE	NUE Balt		21213
20a. METHOD OF DISPOSITION 1 X Surial 2 Cremetion 3 Removal	from State cemete	ACE AND DATE OF DISI	cel		CATION — City o	
4 Donetion 5 Other (Specify)			EM. NOV. 2		BALTO,	MD.
2 SIGNIGE OF FOREIGN SERVICE	χ	Χ. Ι	CALVIN B.	SCRUGGS F	UNERAL	HOME
Caller DR	enugge		1412 E. PR			,MD.21213
23. PART I. Enter the disesses, or comehock, or heart fellure. List	only one cause on each	he desth. Do not en h line.	ter the mode of dying, su	ch as cardiac or reepi	ratory srrest,	Approximats intervel Between
IMMEDIATE CAUSE (Final disease or condition	(7	A h	M. J.	Hoad		Onset and Daath
resulting in death) a	DUE TO (OR AS A C	ONSEQUENCE OF):	ocra of	Mosey		
b.						
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEDUENCE OF):				
CAUSE (Disease or Injury	DUE TO (OR AS A C	ONSEQUENCE OF:				
that initiated evants resulting in death) LAST	201 10 (ON A3 A O	onscore or j.				
d.						
PART II. Other aignificant conditions of	ontributing to death but	not resulting in the	underlying cause given i	n Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
PART II. Other significant conditions c	ontributing to death but	not resulting in the	underlying cause given i	PERFOR		
				PERFOR	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
PART II. Other aignificant conditions of the con	UTE TO CAUSE OF		NO □ UNCERTA	PERFOR	RMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINERY	UTE TO CAUSE OF	DEATH YES D	NO UNCERTA	IN PERFOR	RMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINERY	UTE TO CAUSE OF 26 OSPITAL: Inpution 2 XENOUSE	DEATH YES DEATH (CA	NO UNCERTA	IN PERFOR	RMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 MO 27. MANNER OF DEATH 1 Natural 5 Pending	UTE TO CAUSE OF 26 OSPITAL: Impellent 2 XEN/Outpat	DEATH YES C	NO UNCERTA	IN Other (Specify)	RMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	UTE TO CAUSE OF 26 OSPITAL: Inpution 2 XENOUSE	DEATH YES DEATH COMPLETE TO THE STATE OF THE	NO UNCERTA	PERFORM 1 YES 2 IN D Other (Specify) 28d. Describe How City or Town, State)	NAMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIB	UTE TO CAUSE OF 28 OSPITAL: Impellent 2 (XEN/Outpet) 28a. DATE OF INJURY AND DOS OF INJURY 28a. PLACE OF INJURY	DEATH YES DEATH COMPLETE TO THE STATE OF THE	NO UNCERTA	IN Other (Specify) 28d. DESCRIBE HOW (Street	NAMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIES WAS CASE REFERRED TO MEDICAL EXAMINER 1 YES 1 HO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29 Certiffer 1 Certifying Physicia	UTE TO CAUSE OF 280 DEPITAL: Imparison 2 XERVOLIDATE 280 PLACE OF INJURY — building, etc. (Specify N: To the best of my knowled	DEATH YES E PLACE OF DEATH COM- ONLY ONLY ONLY ONLY ONLY ONLY ONLY ONLY	NO UNCERTA	PERFORM 1 YES 2 IN DITHER (Specify) 286. LOCATION (Street City or Town, State) 287. LOCATION (Street City or Town, State)	and Number or Ruk	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 AT YES 2 NO ITEL Route Number,
DID TOBACCO USE CONTRIES WAS CASE REFERRED TO MEDICAL EXAMINER 1 YES 1 HO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29 Certiffer 1 Certifying Physicia	UTE TO CAUSE OF 280 DEPITAL: Imparison 2 XERVOLIDATE 280 PLACE OF INJURY — building, etc. (Specify N: To the best of my knowled	DEATH YES E PLACE OF DEATH COM- ONLY ONLY ONLY ONLY ONLY ONLY ONLY ONLY	NO UNCERTA sch only one! *EFI: **Hursing Home 5 Residence 28c. BUJURY AT WORKT 1 VES 2 NO factory, office the time, data end place, and d	PERFORM 1 YES 2 1 Other (Specify) 28d. LOCATION (Street City or Rown, State) 28f. LoCATION (Street City or Rown, State) 28f. LoCATION (Street City or Rown, State)	and Number or Ru A but a stated, and due to the cau	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 AVES 2 NO ITEL Route Number,
DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Netural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined 2 MEDICAL EXAMINER: (UTE TO CAUSE OF SPITAL: Impellent 2 XENOUSE 28a. PLACE OF INJURY building, etc. (Specify N: To the best of my knowled on the basis of exemination a	DEATH YES DEATH ICH PLACE OF DEA	NO UNCERTA LEFI: WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT WORKT A WORKT WORKT WORKT A WORKT WORKT WORKT WORKT WORKT A WORKT WO	PERFORM 1 YES 2 1 Other (Specify) 28d. LOCATION (Street City or Rown, State) 28f. LoCATION (Street City or Rown, State) 28f. LoCATION (Street City or Rown, State)	and Number or Ru A but a stated, and due to the cau	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 AVES 2 NO Inal Route Number, Inal
DID TOBACCO USE CONTRIES 25. WAS CASE REFERRED TO MEDICAL EXAMINER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be determined 2 Accident 1 CERTIFIES 1 CERTIFIES 1 CERTIFIES 1 CERTIFIES 2 MEDICAL EXAMINER: 0	UTE TO CAUSE OF SPITAL: Impellent 2 XENOUSE 28a. PLACE OF INJURY building, etc. (Specify N: To the best of my knowled on the basis of exemination a	DEATH YES THE COMPANY OF THE PROPERTY OF THE P	NO UNCERTA Story one) IEFE: Hursing Home B Residence 26c. NULURY AT WORKT I VES 2 NO factory, office he time, data end place, and d my opinion, dasth occurred at till 29c. LICENSE N O • C d	PERFORM 1 YES 2 IN	and Number or Ruk About	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 A YES 2 NO Wall Route Number, 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

IN THE HENTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be relatined by the hospital or attending physician and completely first in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or minimal in the state of the State Dept. of Health and Mental Hygiene prior to burial, cremation or minimal must be notified at once. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

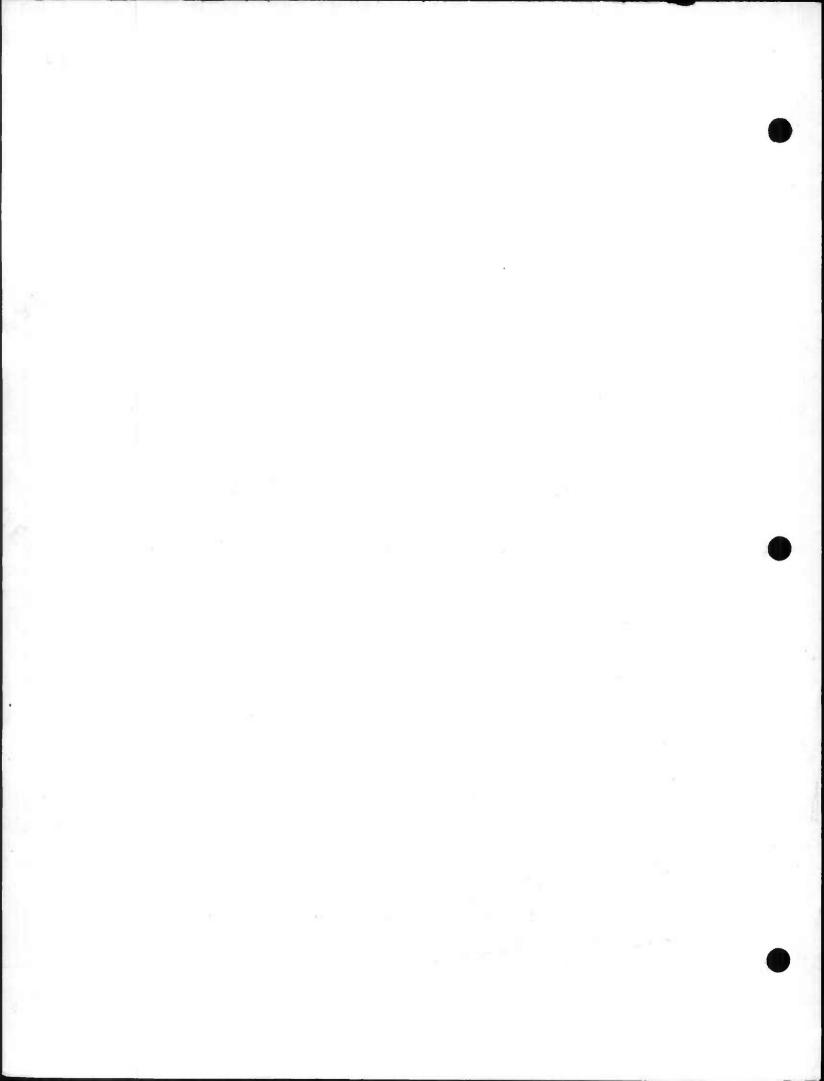
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTM CERTIFICA			MENTAL HYGIE REG. N		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF CEATH		3. TIME OF OEATH
JAMES UPM	AN				NOV. 1	7. 19	95 12:17 P M
4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		a. BIRTNPLACE (State or Foreign Country)
214-46-0239 9e. FACILITY NAME (If not institution, give si		O YRS.	CITY, TOWN O	R LOCATION OF DE	April17	,1947	Maryland
ST.AGNES HOSPI		NTAC					
RESIDENCE OF DECEDENT			BALTI	MORE CI	.T. X		N/A
Maryland 106. COUNTY	N/A		imore	ION			10d. INSIDE CITY LIMITS? 1 ₩ YES 2 NO
10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?
1805 Letitia	Avenue 12. WAS DECEDENT EVER IN L		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	21230			ted States
1 Never Merried 2 X Merried	FORCES? 1 YES	2 (XNO	If yee, spe	cify Cuben, Mexica	ilC ORIGIN? (Specify n, Puerto Rican, etc.)	Yee or No-	14. RACE — American Indian, Black, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES	1 U YES	2 X NO Specify	<i>y</i> .		Specify: White
15. OECEDENT'S EDUI (Specify only highest grade	CATION 1	iae. OECEDENT'S USL			16b, KIND OF	BUSINESS/INDU	
Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mos tired.)	st of working			
12		Elect	ricia	n	tele	com	
t7. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Mak	len Surneme)	
Joseph Upman				Gertru	de Fry		
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AO	DRESS (Street e	nd Number or Rural	Route Number, City or	fown, State, Zip	^{Code)} 21230
Gina Simoni Up		1805 L	etitia	a Avenu	e Balti	more,	Maryland
20s. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Rem	oval from State 20b. P	PLACE AND DATE OF D	plece)				City or Town, State
4 Donetion 5 Other (Specify)	Me	adowrid	ge Mer			rsey,	Maryland
21. SIGNATURE OF FUNERAL SERVICE LIC	A S	2	Ambro		eral Ho		Lansdowne
23. Part i. Enter the diseases, or o	complications that caused i	the death. Do not	12719	Hammon	ds Ferr	y Roa	d 21227
shock, or heart failure.	11.4				h as cardiac or re	eniretory arm	Annovimete
IMMEDIATE CAUSE (Final disease or condition	Aden S	ch line.					interval Between
	a. DUE TO (OR AS A C	ch line.			les Cardiac or re		interval Between
disease or condition	a. DUE TO (OR AS A C	Scherolic Consequence of:					interval Between
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	a. Due to (or as a c	CONSEQUENCE OF):					interval Between
disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. OUE TO (OR AS A C	CONSEQUENCE OF):					interval Between
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa	a. DUE TO (OR AS A C	consequence of:	Card	tovesu	Part 1. 240. WAS	AN AUTOPSY	interval Between Onset and Death 24b. WERE AUTOPSY FINOINGS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	a. DUE TO (OR AS A C	consequence of:	Card	tovesu	Part I. 24a. WAS	AN AUTOPSY FORMED?	interval Between Onset and Death Onset and Death 24b. WERE AUTOPSY FINOINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	a. DUE TO (OR AS A C	consequence of:	Card	tovesu	Part I. 24a. WAS	AN AUTOPSY	interval Between Onset and Death 24b. WERE AUTOPSY FINOINGS AMRIABLE PRIOR TO
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant condition	a. DUE TO (OR AS A C. DUE TO (OR	CONSEQUENCE OF): CONSEQUENCE OF): t not resulting in the consequence of the consequence	he underlying NO Check only one)	g cause given in	Part I. 24e. WAS PER YES	AN AUTOPSY FORMED?	interval Between Onset and Death 24b. WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	a. DUE TO (OR AS A C. DU	CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): t not resulting in the consequence of the consequence	ne underlying NO Check only one) THER: Nursing Hom F 26c, INJ	g cause given in UNCERTAL TO S Reeldence	Part I. 24a, WAS	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 11 YES 2 NO
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XYES 2 NO 27. MANNER OF OEATN Natural 5 Pending	a. DUE TO (OR AS A C. DU	CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): t not resulting in the consequence of the consequence	he underlying Check only one) THER: Nursing Hom F 26c. INJ WO 1 1	g cause given in UNCERTAL 10 5 Reeldence UNRY AT PYES 2 NO	Part I. 24e. WAS PER YES	AN AUTOPSY ORMED? 2 NO W INJURY OCC	24b. WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 11 YES 2 NO
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DIVISION OF VITAL RECORDS, P.O. BOX 6876

NOV 2 0 1995

32. REGISTHAR'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE 1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

REGISTRAR	4								2. DATE OF I	DEATH		-	TIME OF DEATH
1. DECEDENT'S NAME (First, Midd		OND WHI	TE. III						MONTH	DAY	1995	EAR	2:30 A
4. SOCIAL SECURITY NUMBER		s. SEX	6. AGE (In yrs. le:		IF UNDER	1 1 YEAR	IF UNDER	24 HRS.	7. DATE OF E	HRTH			ACE (State or Foreign
N/A						DAYS	HOURS	мін.	November 4,1995			Country	
9a. FACILITY NAME (If not instituti	a. FACILITY NAME (If not institution, give street and number)					r, TOWN	OR LOCATIO	ON OF D	EATH		9c. COUNTY	OF DEAT	ТН
NATIONAL NAVAL MEDICAL CENTER					BETHESDA MONT					TGOMERY			
	LESIDENCE OF DECEDENT 10b. COUNTY					001001	71041	_	_			1 44	d. INSIDE CITY
Virginia Fairfax				Fort Belvoir									LIMITS?
5300 Orchard (O Orchard Court #4						22060				U.S.A		AT COUNTRY?
11. MARITAL STATUS			IT EVER IN II S AI	VER IN U.S. ARMED YES 2 NO 13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico			NIC OBIGINS (S	necity Year			- American Indian,		
1 Never Married 2 Married 3 Wildowed 4 Divorced	ried		YES 2 X				ecify Cuba 2 XNO	Specif	in, Puerto Ricar ly:	n, atc.)		Black, V Specify:	asian
15. DECEDER	NT'S EDUCAT	TION	16a, D	ECEDENT'S	LUSUAL O	CCUPATION	ON		16h KIN	ID OF BUSI	INESS/INDUST		asian
(Specify only high			(0	Bive kind of B. Do NOT u	work done	during mo		ng	Took All	D 01 D001	111200/111000		
Elementary/Secondary (0-12)		College (1-4 or 6	+)	B. DO 1107 B	ao rourou.,								
N/A				N/A					N	/A			
17. FATHER'S NAME (First, Middle,	Last)						18. MOTI	HER'S NA	ME (First, Midd	e, Maiden S	Surname)		
Thomas Edmon	d Whi	te, Jr.					Del	ora I	ynn Wh	eelus	S		
19a, INFORMANT'S NAME (Type/F		,	146	h MAH IN	ADDRES	S (Street	-		Route Number, (rdin)	
Thomas E. & D	*	117124-											
	ebra i	c. white						#4,	Ft. Be				
20g. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3		al trom State	20b. PLACE cemetery, cr						11208	38 20c. LOCATION — City of			, State
	cffy)		Quant	tico N						Tria	angle,	Va.	
4 Donation 5 Other (Spe							ND ADDRE	o address of facility tcastle Funeral Home					
4 Donation 5 Other (Spe 21. SIGNATURE OF FUNERAL SE	RVICE LICEN	VSEE	-	-				le F	uneral	Home	•		
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21. SIGNATURE OF FUNERAL SE 23. PART I. Enter the disee shock, or heart immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in deeth) LAST PART II. Other significent of EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 Netural 5 Penerolation inversions of Check only one) 2 MEDICAL	b. c. c. d. ding attigation lid not be mined	DUE TO DUE TO	AUSE OF DEATH (IT	EOUENCE C EOUENCE C TOUENCE C TOUENCE C TOUENCE C TOUENCE C TOUENCE C TOUENCE C TOUENCE C TOUENCE C	IVER OF): OF): In the unit of the unit o	MOUN 143 r the mo Y AT NO [c only one] R: raining Hor 28c. IN. 1 [ctory, office	Dale Dale Dale Dale Dale Dale Dale Dale	BIVE ING. SUCCESSION OF THE PROPERTY OF THE PR	A., Date the secondary S Part I. 24 Part I. 24 Other (S) 28d. DESCRI 28t. LOCATIC City or T to the cause(to the cause) the time, data and	a. WAS AN A PERFORM YES 2 Decity) DN (Street a own, State) a) and man d place, and	AUTOPSY MED? IX NO NUMBER OF CURRENT AUTOPSY MED? IX NO CONTROL OF CURRENT AUTOPSY MED? IX NO CONTROL OF CURRENT AUTOPSY MED? IX NO CONTROL OF CURRENT AUTOPSY MED? IX NO CONTROL OF CURRENT AUTOPSY MED? IX NO CONTROL OF CURRENT AUTOPSY MED.	24b. WAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	Approximate Interval Betwee Onset and Decided Programme Conset and Decided Programme Conset and Decided Programme Conset and Conset

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1	DECEDENT'S NAME (First,		RENEE WHI	тE				U.S		2. DATE OF D	DAY	4 1995	AR	1:25 A	
-	SOCIAL SECURITY NUME		5. SEX	8. AGE (In vrs. I	last birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF B				CE (State or Foreign	
1	N/A		1 □ M 2 🎇 F	or Proce (iii yra. v	YRS.	MONTHS	DAYS	HOURS	6	Novem	ber 4	,1995	Mary Mary	yland	
	DA THE ONLY AT AN			7377777		9b. CITY		OR LOCATI		EATH		9c. COUNTY			
5	NATIONAL N	ENTER			BE	THESI	DA			MOI	VTGO1	MERY			
HE	10a. STATE 10b. COUNTY				10c. CITY, TOWN								1	10d. INSIDE CITY LIMITS?	
2	Virginia	Fort			Belvoir							1 YES 2 XNO			
S	10e. STREET AND NUMBER 5300 Orchard Court #4 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS OECEDENT EVER FORCES? 1 YES				2200			10f. ZIP CODE						WHAT COUNTRY?	
2									_	NIC ODICINA (S.	analty Van a	U.S.A	-	American Indian	
							If yes, sp		en, Maxic	en, Puerto Ricar		- 1	Specify:	E — American Indian, ck, White, atc. city: LCasian	
3		EDENT'S EDU		16a, I	DECEDENT'S	USUAL O	CCUPATI	DN		16b. KIN	D OF BUSI	NESS/INDUST		-	
COMPLETED	Elementary/Secondary (6	y highest grade 0-12)	College (1-4 or 5 +	-	ile. Do NOT u	se retired.)	during me	DSE OF WORK	ng						
ÉL	N/A				N/A					N	/A	10.0			
3 1	7. FATHER'S NAME (First, M									AME (First, Middl					
u	Thomas Edmo		ite, Jr.							Lynn W					
	Thomas E. &		L. White								Route Number, City or Town, State, Zip Code) Ft. Belvoir, Va. 22060				
- #1	20a_METHOD OF DISPOSITION 1	20b. PLAC cemetery, o	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Quantico National Ceme			eter	1 P≜08 v 95		ation – city		Stata				
	1. SIGNATURE OF FUNERA	L SERVICE LI	CENSEE	>		22.	NAME A	ND ADDRE	ESS OF F	CILITY					
- 1	1	1		_						uneral H		*** 2	2102		
-	23. PART I. Enter the d	leases or	orimplications the	t caused the	deeth Do					i., Dale				Approximate	
- 11	enock, or n IMMEDIATE CAUSE (Fil disease or condition resulting in death)			TABLE ON AS A CONS	DELIV		AT 2	2 WE	EKS					Intervel Between Onset and Deati	
N N	Sequentielly list condit if any, leading to imme cause. Enter UNDERLY	diete	b	(OR AS A CONS	SEQUENCE C	OF):									
HILL	CAUSE (Disease or injuthat initiated events resulting in death) LAS		DUE TO	(OR AS A CONSEQUENCE OF):											
	PART II. Other algnific	ent condition	na contributing to	deeth but no	t resulting	in the u	nderivir	a ceuse	given is	Part 1. 24	. WAS AN	MITOPSY	24b. WI	ERE AUTOPSY FINDINGS	
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3	DID TOBACCO L	ISE CONT	RIBUTE TO CA	USE OF DE	ATH Y	ES 🔲	NO [JUN	CERTA	N 🗆					
PHYSICIAN	25. WAS CASE REFERRED 1 EXAMINER? 1 YES 2 X NO	TO MEDICAL	HOSPITAL:	J-2111-	ACE OF DEA	OTHE	R:								
2	27. MANNER OF DEATH		1 inpatient 2		_		_		Raaldence	6 Other (S)	-	LIURY OCCUE	ED		
	1 X Natural 5	sturel 5 Pending		(Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCUR		LU			
IED BY	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28s. PLACE C building,	28s. PLACE OF INJURY — Al homs, farm, street building, atc. (Specify)							OCATION (Street and Number or Rural Route Number, ity or Town, State)			e Number,	
COMPLETED	const only 21		SICIAN: To the best of ER: On the basis of a										ause(a) ai	nd manner as stated.	
3	296. SIGNATURE AND TH	E OF CERTIFIE	7/1/		. \			29c. LR	CENSE N	JMBER		29d. DATE S	IGNED (M	onth, Day, Year)	
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2	30. NAME AND ADDRESS O					e, Print)		NAT	IONA	L NAVA			CENT	FR	
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J	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Pr	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral of	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examine	
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -REGISTRAR CERTIFICATE OF DEATH 1. OFCEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR A M 1995 2:20 FELECIA LYNN WHITE NOVEMBER 4 4. SOCIAL SECURITY NUMBER 5. SEX 8. BIRTHPLACE (State or Foreign 6. AGE (In vrs. last birtnday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS 1 M 2 X F N/A YRS November 4, 1995 Maryland 9 Se. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF OFATH 9c. COUNTY OF DEATH DIRECTOR NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY RESIDE 10c CITY TOWN OR LOCATION 10a. STATE 105 COUNTY 10d. INSIDE CITY Fairfax 1 YES 2 THO Fort Belvoir Virginia FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 5300 Orchard Court #4 22060 U.S.A. 12. WAS OFCEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 X Never Merried 2 Merried If yee, specify Cuben, Mexican, Puerto Ricen, etc.) 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Caucasian COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. OECEOENT'S EOUCATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementery/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas Edmond White, Jr. Debra Lynn Wheelus BE 19e. INFORMANT'S NAME (Type/Print) 19h, MAILING ACORESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 0 Thomas E. & Debra L. White 5300 Orchard Court #4, Ft. Belvoir, Va. 22060 20e. METHOO OF OISPOSITION
1 X Buriel 2 Cremation 3 Removal from State
4 Doneston 5 Other (Specify) 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Quantico National Cemetery 08-95 Triangle, Va 21. SIGNATURE OF FUNESIAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY
MOUNTCASTLE Funeral Home 4143 Dale Blvd., Dale City, Va. 22193 23. ART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Intervai Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition PREVIABLE DELIVERY AT 22 WEEKS reaulting in death) OUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentially llat conditions, DUE TO (OR AS A CONSEDUENCE OF): if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in desth) LAST 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE PART ii. Other eignificent conditions contributing to death but not reculting in the underlying ceues given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 1 YES 2 NO DF DEATH? 1 ☐ YES 2 ☐ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1X Inpetient 2 - ER/Outpetient 3 - DOA 1 YES 2 X NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF OEATH 26d. OESCR!BE HOW INJURY OCCUREO 1 X Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. (Check only one) Our the beele of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end menner ee stated. 29c. LICENSE NUMBER 29d, OATE SIGNED (Month, Day, Year) BE mi) RES-000 11/6/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print) NATIONAL NAVAL MEDICAL CENTER WALKER, LT, MC, USN RETHESDA MD. 20889-5600 The Street Cap Soutails

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BALTIMORE, MARYLAN

the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the tuneral director, page 5 should be defined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at other.

	REGISTRAR		CE	RTIFIC	CATE O	F DEATH	RE	EG. NO.		
	1. OECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH		3. TIME OF DEATH
	LEWIS	A NUDDENA		FATER T	COII		MONTH	DAY	YEAR	0.57 2 44
	4. SOCIAL SECURITY NUMBER	5. SEX 8. A	GE (In yrs. lest	-	JSCH IF UNDER 1 YEAR	IF UNDER 24 HRS.	NOV.		995	2:57 A.M.M. HPLACE (State or Foreign
	4. SOCIAL SECONITY NUMBER		LINE (III YTS. IRISI		INTHS DAY		7. DATE OF B (Month, Day	(Wear) 8/234	Coun	try)
	216-12-6137	1 💢 M 2 🗆 F	75	YRS.		1646-2	6/24	/20	MA	RYLAND
	9s. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY, TOW	N OR LOCATION OF DE	EATH	9c. CO	UNTY OF	DEATH
Œ	1020 STITTE ONL A	3.COMPTEND		- 1	PAR	KVILLE		B	ALTIN	ODF
2	1830 WHITE OAK A	VENUE			I MI	TATODO		Di	ADT TI	TORE
DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY,	TOWN OR LO	CATION				10d, INSIDE CITY
<u>E</u>	D.	ALTIMORE			עממאם	TITE				LIMITS?
	MAKILAND	ALTIMORE			PARKV					1 YES 2 XNO
FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE		10g. Cl	TIZEN OF	WHAT COUNTRY?
뚭	1830 WHITE OAK AV	VENUE			- 1	21234				USA
5	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARI	AED		ECENDENT OF HISPAN			14. RAC	E — American Indian, ck, White, etc.
	1 Never Married 2 K Married	FORCES? 1 X Y		0		specify Cuban, Maxica ES 2 XNO Specifi		, atc.)	Spe	
В	3 Widowed 4 Divorced	WW II			, ,	Es 2 KNO Specii	у.		Sper	WHITE
	15. DECEDENT'S EDUC			CEDENT'S II	SUAL OCCUPA	TION	16P KIN	D OF BUSINESS/IN	IDIICTBY	
쁘	(Specify only highest grade		(GA	re kind of wo	rk done durina	most of working	100, 6114	D OF BOSINESS/III	DOSINI	
	Elementary/Secondary (0-12)	College (1-4 or 5+)								
4	12th GRADE		EL	ECTRI	CIAN			STEEL CO)	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First, Middle	e, Maiden Surname)		
E C	VINCENT ANDREW W	JET.SCH				CHART.	OTTE L	EWIS		
00	19a. INFORMANT'S NAME (Type/Print)	THEOCIT	191	MAILING	INDRESS (Street	et and Number or Rural			Zin Code)	
2										07.004
	MARIE JOSEPHINE W	WELSCH		1830	WHITE	OAK AVENU	E PAR	KVILLE,		21234
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Rame	med form State	20b. PLACE A		DISPOSITION	(Name of	OATE	20c. LOCATION -	- City or T	own, Stata
	4 Donation 5 Other (Specify)	DVIII (TOTAL STATE)			er piace) CEMETE	RY	11/11/	95 BAT.T	TMOR	E, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	211100	1002		ANO ACORESS OF FA		33.12.2	2.101	
	101 -	+ V		11	JOHN	ISON FUNER	RAL HOM	E		
	(Meslinia	X MA	week	K	852	LOCH RAV	EN BLV	TOMOT	. MOS	MD 21286
	23. PART i. Enter the diseases, or o	compilcations that ceu	sed the de	eth. Do no						Approximeta
	ehock, or heart fellure.	List only one ceuse of	n eech ilne							intervel Bstween
	IMMEDIATE CAUSE (Finel				0					Onset end Desth
	disease or condition resulting in death)	. (-	-45D	RIC	6	meer				
		DUE TO (OR	AS A CONSEC	UENCE OF						
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ō	Sequentially list conditions,	DUE TO (OR	AS A CONSEC	UENCE OF	:					
A	if sny, leading to immediate csuse. Enter UNDERLYING									
CERTIFICATION	CAUSE (Dieesse or injury	C	AS A CONSEC	LIENOE OF						
쁜	thet initiated events	DUE TO (OR .	AS A CONSEC	DUENCE OF	1.					
Œ	resulting in death) LAST	d,								
2										
A	PART II. Other significent condition	e contributing to dee	th but not r	eeulting li	the underly	ing ceuse given in	Part i. 24a	PERFORMED?	Y 24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL								YES 2 NO		COMPLETION OF CAUSE OF DEATH?
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Σ	DID TODACCO LICE CONTE	DIDLITE TO CALICI	OF DEA	TII VE	CI NO	UNCERTAL				1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTI	KIBUTE TO CAUSI					иП			•
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF OEATI	I (Check only d	ne)				
S	t TYES 2 NO	1 Inpetient 2 ER/	Outpatient 3	□ DOA	OTHER: 4 Nursing I	iome 5 Besidence	e Other (Sp	pecify)		
¥	27. MANNER OF OEATH	26a. DATE OF INJU	JRY	28b. TIME	OF 28c.	INJURY AT		BE HOW INJURY O	CCURED	
	1 Herrural 5 Pending	(Month, Day, Ye	ear)	INJU		WORK? YES 2 NO				
ВУ	2 Accident Investigation	2 Accident Investigation								
	3 Sulcida e Could not be	28a. PLACE OF IN. building, atc.		me, tarm, si	reet, tactory, o	ffice	City or To	N (Street and Numbown, State)	per of Hura	Houte Number,
1	4 Homicide determined									
COMPLETED	29a. CERTIFIER	CIAN: To the best of my I	ramuladas da	oth coours	d et the time	tate and place and du	. t. th	\d =	ded and	
N N	one)									veniera-mior
Ö	MEDICAL EXAMINE	:H: On the besis of exami	nation and/or	rivestigation	i, in my opinio	n, death occured at the	e time, data and	piaca, and dua to	the ceuse	(a) and manner as stated.
	296. SIGNATURE AND TITLE OF PENTIFIE					29c. LICENSE NU	MBER	29d. D	ATE SIGNE	D (Month, Day, Year)
BE	296. SIGNATURE AND TITLE OF DESTRICT	Man Man				29c. LICENSE NU	MBER 79	29d. D	ATE SIGNE	D (Month, Day, Year)
BE	Mul Cell	ano, m	F 054711 #==		Delegal	29c. LICENSE NU	1 Z 9	29d. D	ATE SIGNE	9 /9 +
ш	30. NAME AND ADDRESS OF PERSON WH	ano, m	F OEATH (ITE	4 27) (Type,	1	D309	129 129	29d. D	ATE SIGNE	9 /9 +
BE	Mul Cell	ano, m	F OEATH (ITE	u 27) (Type,	1	D309	129 #205	29d. D. → M O	ZI	9/95 264
BE	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O M 656 132. REGISTRAR'S	F OEATH (ITE	1 27) (Type,	1	D309	# 205	29d. D.	ATE SIGNE	9 /9 F

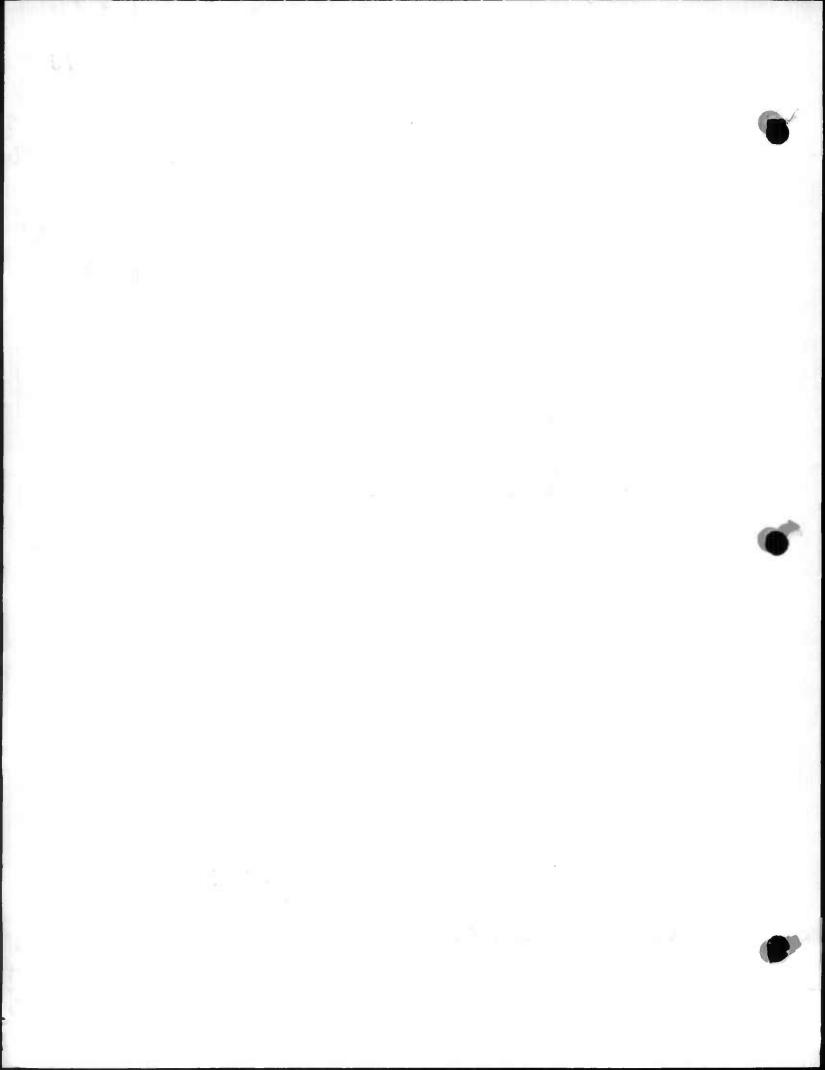
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DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-1. hours after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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SPITAL (VERAL D	AT: H H
TO THE HO	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTAL

	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPA	RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)	rt Wych	10		7EAR 3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 227-18-6774	5. SEX 1 M 2 F 6. AGE (In yrs. lest birthday) 1 M 2 F 76 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Pay, Year) 9	BIRTHPLACE (State or Foreign Country)				
TOR	9a. FACILITY NAME (If not institution, give s FU CYGY CYCL RESIDENCE OF DECEDENT	NSA + Rehab	86. CITY, TOWN OR LOCATION OF D		Y OF DEATH				
DIRECTOR	10a. STATE 10b. COUNTY	NONE 10c. CI	TY, TOWN OR LOCATION Baltimos	u	10d. INSIDE CITY LIMITE? 1 Es 2 NO				
ERAL	100. STREET AND NUMBER 2525 W. Belo	refere ave	10f. ZIP CODE 2/2/	1 S 10g. CITIZE	N OF WHAT COUNTRY?				
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATBS	13. WAS DECENDENT OF HISPA If yea, specify Cuban, Mexic 1 YES 2 NO Speci	an, Puerto Ricen, atc.)	I. RACE — American Indian, Black, White, atc. Specify:				
ETED E	15. DECEDENT'S EDU (Specify only highest grade	(Give kind of	S USUAL OCCUPATION work done during most of working	16b. KIND OF BUSINESS/INDUS	STRY				
COMPLE	Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)	Collega (1-4 or 5 +)	KNOWN	UNKNOU	W				
BE CC	UKIKIYOW	11	18. MOTHER'S N.	AME (First, Middle, Maiden Surname)					
10 8	190. INFORMANT'S NAME (Type/Print)	FIELD 196 MAILIN	PARK AND BA	Route Number, City or Town, State, Zip Co	2.01				
	20e METHOD OF DISPOSITION 1 Suriet 2 Cremation 3 Rem 1 Donation 5 Other (Specify)	20h PLACE AND DATE	OF DISPOSITION (Name of other place)	DATE 20c. LOCATION - CH	y or Town, State				
	21. SIGNATURE OF FUNERAL SERVICELLE	CENSEE	22. NAME AND ADDRESS OF F		AL:				
	Many Samuel	C. Jon	HOII PARK HE	ights AVEI BAlto.	Md. 21215				
	shock, or heert fellure. IMMEDIATE CAUSE (Finel	complications that caused the deeth. Do List only one cause on each line.	not enter the mode of dying, suc	ch es cerdiac or reepiratory erree	t, Approximate interval Between Onset and Death				
	disease or condition resulting in death) Due to (on As a consequence or):								
NO	Sequentielly list conditions, Due TD (OR AS A CONSEQUENCE OF)								
ICATI	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	6.	<i>'</i>						
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE Of	OF);		į				
AL C		ne contributing to deeth but not recuiting	In the underlying ceuse given in	Part I. 24a, WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS				
MEDIC	CHE 1	.•		1 TYES 2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
W	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DEATH Y	FS \(\text{NO} \(\text{N} \) UNCERTAL		1 TYES 2 NO				
PHYSICIAN:	25. WAS CASE REFERRED DO MEDICAL EXAMINER?	26. PLACE OF DEA	ATH (Check only-one)						
YSI	t YES 2 70	HOSPITAL: 1 Inpetiant 2 ER/Outpetient 3 DOA	OTHER: 4 Nursing Home 5 Residence	6 Other (Specify)					
ву Рн	27. MANNER OF DEATH 1 Chatural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TII	ME OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCUR	RED				
	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At home, farm, building, atc. (Specify)	atreet, factory, office	26f. LOCATION (Street end Number or City or Town, State)	Rural Route Number,				
COMPLETED		CIAN: To the best of my knowledge, death occur R: On the bests of examination and/or investiget							
H	296. SIGNATURE AND TITLE OF CERTIFIES	MO	29c. LICENSE NU	- (0	IGNEO (Month, Day, Year)				
٩	38. HAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF DEATH (ITEM 27) (Type	Print) Reisterston	Pel #24					
ı	NOV1 81995	2, REGISTRAR SIGIRATURE	100	, , , ,					



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TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: At be filed within 72 hours after de IMPORTANT; If item 28 Is I

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bu		
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OR	E H	100	len

95 34971 Item# 1. G-film 729 per fh. 11/17/95 P.C FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) William David 2. DATE OF DEATH 3. TIME OF DEATH Yarworth YEAR WILLIAM 6:45 P NOVEMBER 12 1995 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 💢 M 2 🗌 F 29 1966 216-78-7174 April Maruland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Bayview Medical Ctr. Baltimore City N/A RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Baltimore City 1 X YES 2 NO Maryland N/A FUNERAL 10e. STREET AND NUMBER 10t. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3419 Leverton Avenue 21224 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 100 IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 🔀 Never Merried 2 🗌 Merried It yee, specify Cuben, Mexicen, Puerto Rican, etc.) 1 TYES 2 X NO Specify: BY 3 Widowed 4 Divorced White ED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 9 Years Crew Leader Food Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Gertrude L. Taylor Roy Yarworth BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 2 3419 Leverton Avenue Baltimore, MD 21224 Sam Ireland DATE 20c. LOCATION - City or Town, State Halltop Service Corp. 11/18/95 Towson, Maryland 21. SIGNATURE OF PLANSFOAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliurs. List only one cause on each line. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Finsi disease or condition RESPIRATORY APREST resulting in death) MINUTES OUE TO (OR AS A CONSEQUENCE OF): 4 DAYS PNEUMONIA CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING AUTOIMMUNE DEFICIENCY SYNDROME (4)DS) 2 YEARS END STAGE CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERF AUTOPSY FINDINGS 24a. WAS AN AUTOPSY MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t X YES 2 - NO 1 - YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE DF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 12 Inpatient 2 ER/Outpatient 3 DOA 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 28c. INJURY AT WORK?

1 YES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending BY Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER 1 1 📆 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated. 2 MEDICAL EXAMINER: On the beste of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
CAN LYN HOUK MID. JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4940 EASTERN AVENUE BALTIMORE, no 21224

29c. LICENSE NUMBER

96008

31. DATE FILED (Month), NOV 1 32. REGISTRAB'S SIGNATURE

29b. SIGNATURE AND TITLE OF CERTIFIER

Carolyn Houk M.D.

29d. DATE SIGNED (Month, Day, Year)

NOVEMBER 12, 1995

8 9 9

34972 95

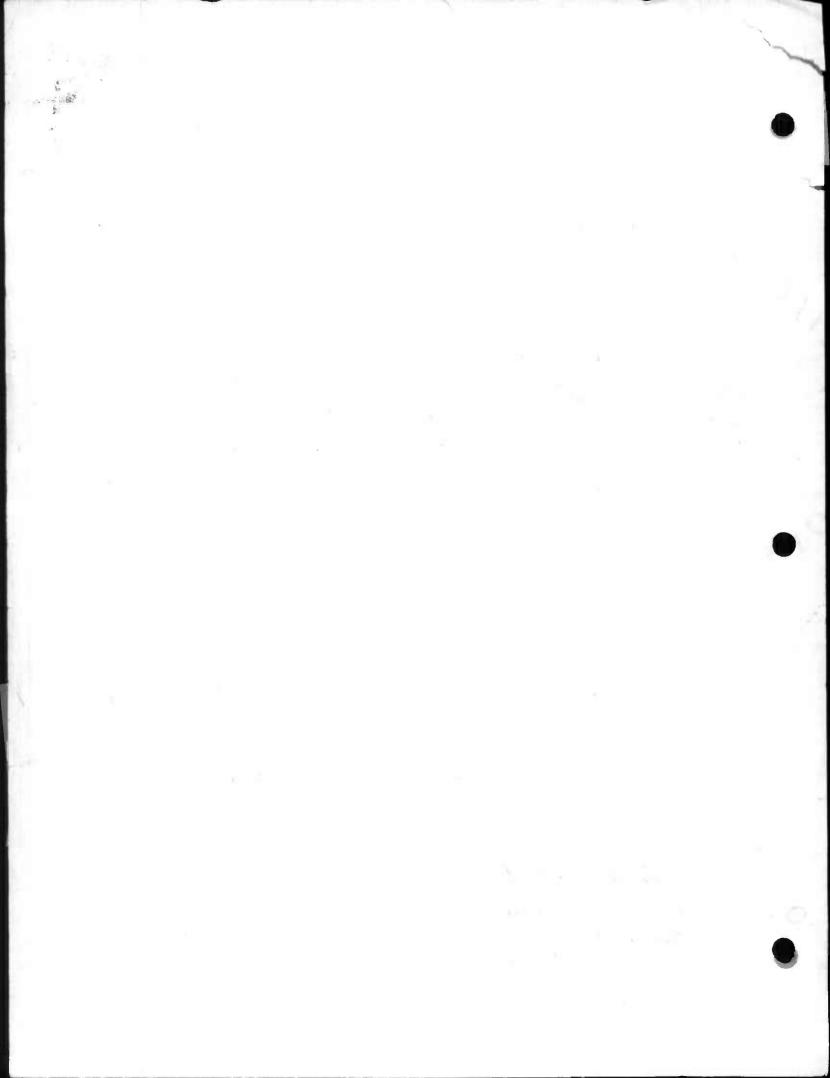
	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Last)		_			2. DATE OF DEATH	DAY	3. TIME OF DEATH
	PRESTON 4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		AUSTIN		NOVEMBER	14 1	.995 03:29 Am
	218-60-3104		(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept 27,		8. BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give st		r I	9b. CITY, TOWN C	OR LOCATION OF D			I'IU I'Y OF DEATH
OR	3820 COTTAGE A	4VE	1	BALTIM	ORE		N	/A
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	1	10c. CITY	, TOWN OR LOCAT	ION			10d, INSIDE CITY
	Md N/A		Bal	timore				1 AYES 2 NO
!AL	10a. STREET AND NUMBER	-			. ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY?
FUNERAL	3820 Cottage Ave				21215			SA
	11. MARITAL STATUS 11 Never Married 2 Married	FORCES? 1 YES 2 NO			ecify Cuban, Maxica	NIC ORIGIN? (Specify Ya in, Puerto Rican, etc.)	a or No- 1	14. RACE — American Indian, Black, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR ON (DATES	1 U YES	2 NO Specif	y:		Specify: Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Give kind of w	USUAL OCCUPATION	ON st of working	16b, KIND OF BL	SINESS/INDU	STRY
12	Elamentary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT us	ŕ		D - 6:		
OM	7th grade 17. FATHER'S NAME (First, Middle, Last)	N/A	Roofe	r	18. MOTHER'S NA	Roofi ME (First, Middle, Malder		
BE C	Raymond E. Aust	in, Sr			Doroth	ny Boggs		
10	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural	Route Number, City or Tox Baltimore	vn, State, Zip C	1315
	Dorothy Byrd							
20s_METHOD OF DISPOSITION 1X_METHOD OF DISPOSI						lty or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY							
	March F/H West 4300 Wabash Avenue Baltimore, Md 2						more Md 21215	
	23. PART I. Enter the diseeses, or o shock, or heert failure.	omplications that ceuse	d the deeth. Do n	ot enter the mo	de of dying, suc	h ae cardiec or reap	iratory erre	at, Approximata
	IMMEDIATE CAUSE (Finel	List brily blie cause on	racii iirię.					Interval Between Onset and Deeth
	disease or condition resulting in death)	NARCOTIC INT	OXICATION A CONSEQUENCE OF					
2		DOE TO (OR AS	A CONSEQUENCE OF	·}:				
일	Sequentially liet conditions, if any, leeding to immediate	DUE TO (OR AS	A CONSEQUENCE OF	7):				
2	CAUSE (Disease or Injury	C. DUE TO (OR AS	A CONSEQUENCE OF					
CERTIFICATION	that initiated events resulting in deeth) LAST	DOE TO (OR AS	A CONSCOUENCE OF	7:				
	PART II. Other aignificent condition	s contributing to death	but not requising i	- ab				
CAL	TAIT II. Other alignmeetic condition	s contributing to deeth i	but not reculting i	n the underlying	g ceuee given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						1 X YES	2 NO	OF DEATH?
2	DID TOBACCO USE CONTE	RIBUTE TO CAUSE (OF DEATH YE	S NO [UNCERTAI	N D		1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT					
YSI	1 [XYES 2 NO	1 Inpetiant 2 ER/Out	petient 3 DOA	OTHER: 4 Nursing Hom	a 5 XRaaldanca	6 Other (Specify)		
1 1	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIMI	URY WO	RK?	28d. DESCRIBE HOW	INJURY OCCU	PRED
ВУ	2 Accident Investigation 3 Suicide av V Could not be	FOUND: 11-1	Y — At home, farm, s		N.W.	UNKNOWN 281. LOCATION (Street	and Number o	Pural Bouts Number
TED	4 Homicide BXX Could not be determined	building, atc. (Spe	OUND: RESID			City or Town, State BALTIMORE.	3820 CO	OTTAGE AVENUE
F	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my know	viedga, death occurre	d at the time, date	end place, and due			
COMPLET								ceuse(a) and manner ea atated.
BE (296. SIGNATURE AND TITLE OF CERTIFIER	11			29c. LICENSE NUI		29d. DATE	SIGNED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO	1 My	EATH (ITTH AT	Drien	O.C.M.	Е.	NOVEN	1BER 14 1995
	THE UNOLE M	1. KIND			reet. F	Baltimore	. Мат	ryland 21201
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN					,	7.2010 21201
	NOV 2 1 1995 /	un d'audiente	wallis.					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 6876

OHMH-16 Rev 1/89



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float heart float of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARY		NT OF HEALTH AND		SIENE i. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEA		3. TIME OF DEATN
	DOROTHY	MAE	ALLEN		NOV	15 199	5 1:15 A M
	The second secon		E (In yrs. last birthday) F U	HOER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Y	nert	BIRTHPLACE (State or Foreign Country)
	220-24-9853 9e. FACILITY NAME (If not institution, give str	1 □ M 2 X X F 66	YAS.	CITY, TOWN OR LOCATION OF	June	17, 1929	N.C.
œ			90.		DEATH	9c, COUNTY	
DIRECTOR	2503 Woodland Ave	nue		/Baltimore		N/.	A
Ä	10e. STATE 10b. COUNTY		10c. CITY, 101	VN OR LOCATION			10d. INSIDE CITY
	Md N/	'A	Baltir	nore			1XX YES 2 □ NO
₹	10e. STREET AND NUMBER			101. ZIP CODE		-117-	OF WHAT COUNTRY?
FUNERAL	2503 Woodland Av			21215			S A
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 X X10	13. WAS DECENDENT OF HISP If yea, specify Cuban, Mex	can, Puarto Ricen, e		RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 TES 2 XNO Spe	cify:		Black
8	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION	16a. DECEDENT'S USUA	L OCCUPATION	16b, KIND (OF BUSINESS/INDUS	
ᄪ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retir	one during most of working ed.)			
MP	12th grade	N/A	House ke	eeper	Pri	vate Fami	ly
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				NAME (First, Middle, I		
BE	Tom Hatcher				<u>le Gran</u>		
2	19a. INFORMANT'S NAME (Type/Print)		100000000000000000000000000000000000000	RESS (Street and Number or Run			
	Grace Pulliam po method of disposition			yola Northwa			
	Donation 5 Other (Specify)	val from State	Ob. PLACE AND DATE OF DIS			oc. LOCATION — City Randallst	
	21. SIGNATURE OF FUNERAL SERVICE LICE		King Hemot	22. NAME AND ADDRESS OF		tandarisa	own, na
	47	H. N				300 MAR	ASH AVE
	Mime	II AN	myoson JR	MARCH F/H	Baltimo	~ Md 2121	S AVE
	23. PART I. Enter the diseases, or coshock, or heart failure. L	omplications that cous let only one cause on	ed the death. Do not a each line.	ntar tha moda of dying, a	uch as cardiac or	reapiratory arrest	Interval Batween
	IMMEDIATE CAUSE (Finel disease or condition	10-1-	Ll. C.		N 1.		Onset end Death
	recuiting in deeth)	INTE TAS	S A CONSEQUENCE OF:	nurof	Duode	nun -	
_	_	1.1	1				
ő	Sequentially list conditione, if any, leading to immediate	DUE TO (OR A!	A CONSEQUENCE OF:	. \			
CAT	cause. Enter UNDERLYING	Diab	etes Me	lites			
Ě	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	S A CONSEQUENCE OF):				
CERTIFICATION	resulting in deeth) LAST	l					
AL C	PART II. Other algnificant conditions	e contributing to death	but not resulting in th	underlying ceuse given	In Part I. 24a. V	WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
SA	None				l e	YES 24 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC					'	123 X 110	OF DEATH?
2	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YES	NO NUNCERTA	NIN 🗆		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (C				
SIC	1 TES 2 THO	1 Inpatient 2 ER/O		HER: Nursing Nome 5 Residence	a 8 Other (Spec	ify)	
H	27. MANNER OF DEATH	28e. DATE OF INJUR (Month, Day, Year	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE	HOW INJURY OCCUP	RED
1 Netural 5 Pending 2 Accident Investigation Netural 5 Pending M 1 YES 2 NO							
ED	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJU building, atc. (S	IRY — At home, term, street pecify)	tectory, office	281. LOCATION City or Town	(Street and Number or , State)	Rural Route Number,
ETE							
COMPLET				the time, data and place, and o			
Ö	21 MEDICAL EXAMINE	4: On the beele of examina	tion and/or investigation, in	my opinion, death occured at	he time, data and pi	ece, and due to the c	ausefs) and manner as stated.
BE C							
	ALL V	V 74- 1					
	Mus	Attendit	inysic.	4N 03E	528	P (15/95
10	30. NAME AND ADDRESS OF PERSON WHO				528	72	15/95
	30. NAME AND ADDRESS OF PERSON WHO 7 2 11 PAR (31. DATE FILED (Month, Day, Year)	Atten disconnected cause of HEIGHT	s AVE.	301timore	528 mu 21	208	15/95

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TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		RTMENT OF H		MENTAL HYGIEN REG. NO	_	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Arunah Shep	herdson Abell,	IV			November		95 8:15 A M
		5. SEX 6. AGE (In yrs. I		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	217-24-6493	1 X M 2 □ F 67	YRS.	MONTHS DAYS	HOURS MIN.	May 16. 1		Maryland
	9a. FACILITY NAME (if not institution, give street			9b. CITY, TOWN	OR LOCATION OF DE			OF DEATH
R	8028 Thornton Roa	ad		Rux	ton		Balt	imore County
DIRECTOR			I				Date	
				Y, TOWN OR LOCA	ION			10d. INSIDE CITY LIMITS?
	Maryland Baltir	more County	B	altimore				1 YES 2 NO
M I	111111111111111111111111111111111111111	1		10	. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?
FUNERAL	215 Midhurst Road		-		21212			USA
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. / FORCES? 1 YES 2]NO			IIC ORIGIN? (Specify Yea n, Puerto Ricen, atc.)	or No- 14	RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES ?	7	1 TYES	2 NO Specifi	y:		Specify: White
E	15. DECEDENT'S EDUCA		DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BU	SINESS/INDUS	
	(Specify only highest grade co	ompleted) College (1-4 or 5 +)	(Give kind of ife. Do NOT u	work done during me se retired.)	st of working			
립	201101121700010217		rchite	ect		Archi	tectur	Α.
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden		
BE C	Arunah Shepherdso	on Abell III						
	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (Street a	and Number or Rural	Route Number, City or Tow	n, State, Zip Co	ode)
유	Arunah S. Abell,	Jr.	800 1	Ridgelei	ch Road.	Baltimore	. Marv	land 21212
	20a. METHOD OF DISPOSITION 1 Durial 2 Cremation 3 Remov	20b.PLAC	E AND DATE	OF DISPOSITION (NE				y or Town, Stata
	4 Donation 5 Other (Specify)	Gree	eramatory or o	int Crem	atory	11/20 Ba	ltimor	e, Maryland
	21. BIOHAPURE OF FUNERAL SPRINCE LIGHTE	NSEE						
	* / KALUSACE SON	Mass		Mitc	nell-Wie	defeld Hom	e, Inc	aryland 21212
11	23. PART I. Enter the diseases, or co	implications that caused the	deeth. Do	not enter the mo	de of dying, suc	h es cerdiec or resp	Iratory srres	t, Approximate
		st only one cause on each li	ne.					Intervel Between Onset end Death
ļ	IMMEDIATE CAUSE (Finel diseese or condition	Lung	Cho	CFR	MOH	10 CARCI	nom	
ľ	resulting in deeth) e.	DUE TO (OR AS A CONS	EOUENCE C	OF):	0,00			. 011100
z								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EQUENCE C	F):				
S	ceuse. Enter UNDERLYING CAUSE (Diseese or Injury							
E	thet initiated events resulting in deeth) LAST	DUE TO (OR AS A CONS	EOUENCE C	PF):				
EH	d.							
	PART II. Other eignificent conditions	contributing to deeth but no	t resulting	In the underlyin	g cause given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
MEDICAL	BRAIN MI	-TAITES				PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
				1				OF DEATH?
≥	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DE	ATH Y	ES IT NO T	UNCERTAI	NΠ		1 163 2 100
A	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)	2 011001111111			
PHYSICIAN:		HOSPITAL: 1 Inpatient 2 ER/Outpetient	3 DOA	OTHER:	ne 5 Linealdence	6 Other (Specify)		
Ä	27. MANNER OF DEATH	28a. DATE OF INJURY	26b. TII	IE OF 26c. IN.	URY AT	28d. DESCRIBE HOW	NJURY OCCU	RED
ВУ Р	1 Natural 5 Pending	(Month, Day, Yeer)	174		YES 2 NO			
	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJURY — At building, etc. (Specify)	home, term,	street, factory, offic		261. LOCATION (Street City or Town, State)		Rural Route Number,
TED	4 Homicide determined					City or lown, State,		
COMPLET	29a. CERTIFIER 1 CHeck only	IAN: To the best of my knowledge,	death occur	red at the time, date	and place, and due	to the cause(s) and me	nner as atated.	
WC	one) —	On vie pesis of examination and/o						
	29b. SIGNATURE AND TITLE OF CERTIFIER	\vee			29c. LICENSE NU	MBER	29d. DATE S	SIGNED (Marris, Day, Wag)
BE	0/1.1 C	Jan.				670	▶ 11	19/95
2	39, NAME AND ADDRESS OF PERSON WHO	COMPLETED AND DEATH OF			VIU	010		11111

Chase Street, Baltimore,

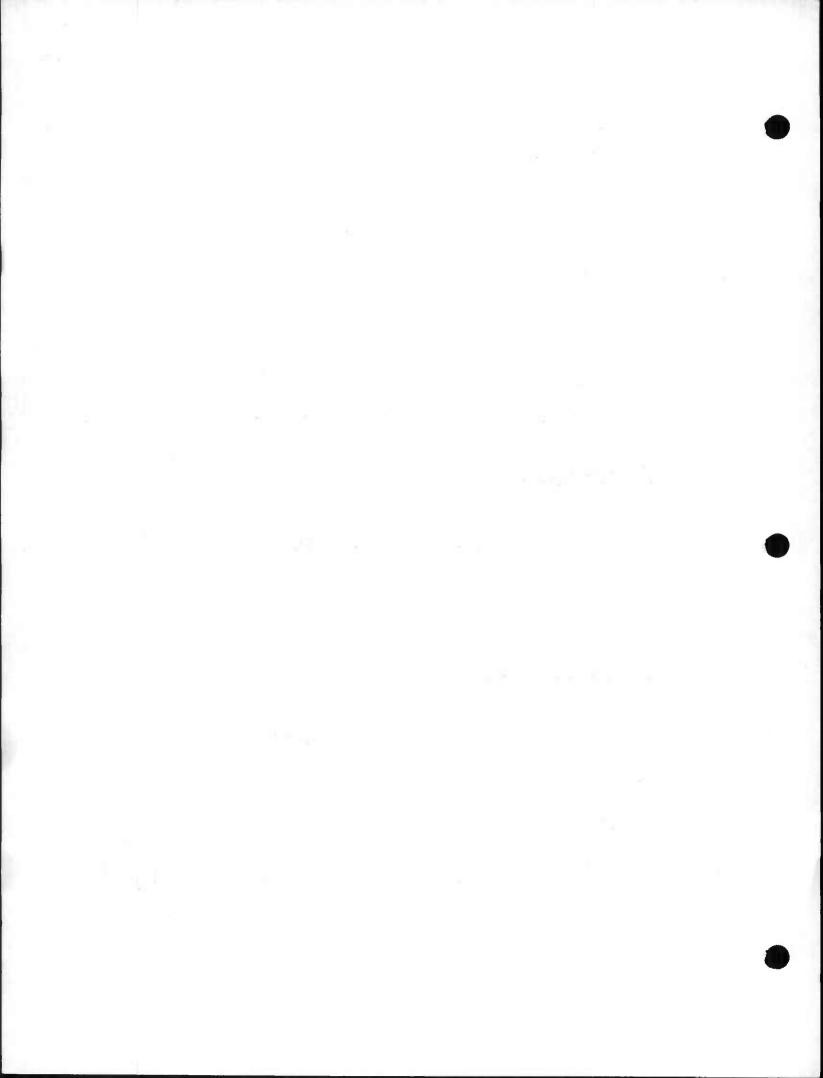
12

30. NAME AND ADDRESS OF PERSON WHO COMPLETED

Sapir

oir M.D. 9 F. C.

Daniel G. S. 31. DAT NO. 1995



BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the for be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT; If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

_	HEGISTHAN		,	PENTIL	CALE	UF	DEATH	1	R	EG. NO.			
ď	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF I	DA	NY.	YEAR	3. TIME OF DEATH
	Velma E. Ankr	U 111						_				1:30 PM M	
	485-24-6578	5. SEX 1 □ M 2 ☑ F	6. AGE (In yrs. 91	lest birthday) YRS.	IF UNDER	IONTHS DAYS HOURS MIN. (Month, Day, Year) Count				Country			
	9a. FACILITY NAME (If not institution, give a		9h CITY	TOWN (OR LOCATION			24, I		LOWA			
5	14003 Manor Road					ldw		OF DEA				ltimo	
5	RESIDENCE OF DECEDENT												10
DIRECTOR		cimore		10c. CIT	Y, TOWN O		HON						10d. INSIDE CITY LIMITS?
-	Maryland Balt	rinore			Date		ZIP CODE						1 YES 2 NO
FUNERAL	14003 Manor Road	1				100		210:	10			J.S.A	
NO.	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. 1	WAS DEC	ENDENT OF H			pecify Yea			- American Indian,
BY	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2)	(]NO		I yes, sp	ecify Cuben, M 2 X NO 5	faxican,	Puerto Ricar	n, etc.)		Specific White	, White, atc. y:
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)		DECEDENT'S (Give kind of a	work done o	CCUPATIO	ON st of working		16b. KIN	D OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	-)	life. Do NOT us	retired.)		•		D-			0.1	
M	17. FATHER'S NAME (First, Middle, Last)			Sate	s Cl	erk		_				Sto	re
ŭ	Charles Seamands						18. MOTHER			e, Maiden	Sumame)		
BE C	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a	nd Number or F			lity or Town	. State 7h	p Code1	
2							load E						13
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remo	oval from State	20b. PLAC	E AND DATE	OF DISPOS	ITION /Na	me of		DATE	20c. LO	CATION	City or Tox	vn, Stata
	4 Donation 5 Other (Specify)									Webs	ebster City, Iowa		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE E. J. Sassahw					F.	Lassahn	Fu	neral			7	04007
	23. PART I. Enter the diseases, or o			death. Do r	ot anter	the mo	Belai	LT K	Oad cardlec	King	SVIL	le,Mo	. 21087
	ahock, or heert failure. I	List only one cau	se on each II	ne.						or roupi	alory at	,	Interval Between Onset and Death
Ì	DUE TO (OR AS A CONSEQUENCE OF):									1.00			
8	Sequentially list conditions. b. So chemia yeo												
Ě	th any, leading to immediate cause. Enter UNDERLYING												
EDICAL CERTIFICATION	CAUSE (Disease or Injury thet initiated events	DUE TO	OR AS A CONS	EOUENCE OF	OUENCE OF):					-			
E	resulting in death) LAST	1											
	PART II. Other significant condition:	s contributing to	death but no	t resulting l	n the un	derivino	Cause alve	n in Pa	rt 1 240	. WAS AN	ALITTOREV	245	WERE AUTOPSY FINDINGS
<u></u> <u>5</u>							, cause give			PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE
									- ''	YES 2	NNO		OF DEATH?
Σ	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DE	ATH YE	S 🗆 N	10 L	UNCER	TAIN	M				T TES 2 NO
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ACE OF DEAT	'H (Check o	only one)							
XS.	1 TYES 2 NO	HOSPITAL:	ER/Outpetlant	3 🗆 DOA	OTHER 4 Nurs		5 🗆 Reside	ence 6	Other (Spi	ecify)			
F	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, De		26b. TIMI INJ	E OF URY	28c. INJ WO	URY AT RK?	2	6d. DESCRIE	BE HOW IN	JURY OC	CURED	
à l	2 Accident Investigation	280 DI ACE OI	E IM H IPPW A.		м		ES 2 NO						
3 Suicide 6 Could not be determined 4 Homicide 4 Homicide City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							nd Number	r or Rural Re	oute Number,				
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINEI												and menner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER MOU K COM	ns t	S				29c. LICENSE	ts 2	ER		29d. DAT	E SIGNED	Month, Day, Youl)
F	30. NAME AND ADDRESS OF PERSON WHO	completed caus	346	EM 27) (Typer	grint) GAR	11	MILI	()	PD.	P41	180	18.	MD 21131
	31. DATE FILMOV 8 1 1995	REGISTRAL	R'S SIGNATURE	della							-	1	



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BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certi

DIVISION OF VITAL RECORDS, P.O. BOX 68760

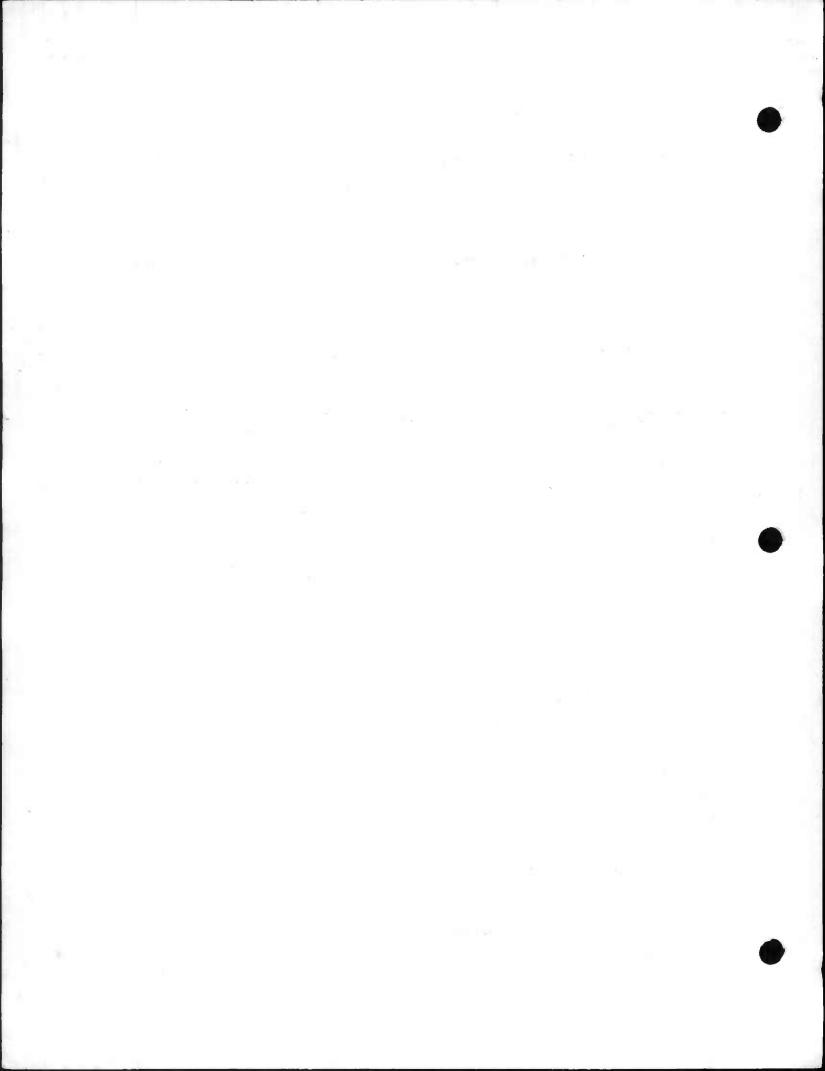
						9:	0 3	149/6
1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATN
ALICE B A	ALT				November	17	1995	3-30AH
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. I	last birthday)	IF UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN			PLACE (State or Foreign
213-18-9705	1 - M 2 - F 90	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	00-	Country	
9a. FACILITY NAME (If not institution, give:	100		9h CITY TOWN	OR LOCATION OF D	Aug. 10, 1		Mary	
						9c. C001		
Harbor Hospit RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland	ar center		Balt	o.City,	Ma.		nor	1e
A. ATATE								10d. INSIDE CITY
Maryland	none	l B	alto C	ity,Md.				LIMITS?
				. ZIP CODE		100 CITI		HAT COUNTRY?
1216 Pa	tapsco St.			21230				
10e. STREET AND NUMBER 1216 Pa 11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. A	DMED	40, 200, 000					States
	FORCES? 1 YES 2 X	NO	If yes, ap	ecify Cuban, Mexica	NIC ORIGIN? (Specify Yes an, Puerto Ricen, etc.)	or No-		- American Indian, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TYES	NO Specif	y:		Specify	White
	CATION 160 F	DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BUS	INCOCUMO		
(Specify only highest grade	completed)	(Give kind of vife. Do NOT us	vork done during m	ost of working	100. KIND OF BUS	HINE 35/IND	USINY	
Elementary/Secondary (0-12) 6th.Grade	College (1-4 or 5+)	0	des Dis				_	
15. DECEDENT'S EDU. (Specify only highest grade Etementary/Secondary (0-12) 6 th . Grade 17. FATNER'S NAME (First, Middle, Last)	none	Can	dy Dip				Cano	ly Co.
	ry L. Thie				AME (First, Middle, Maiden :			
				Alice				1
190. INFORMANT'S NAME (Type/Print) Mr. Joseph A, Al					Route Number, City or Town			
HI . O C C C H A / AI		121	1 5.Ha	nover S	t.Balto.N	Ma.	2123	30
20e. METNOD OF DISPOSITION 1 □ Buriel 2 □ Cremation 3 □ Rem	20b. PLACI	E AND DATE (OF DISPOSITION (National Property of the Colored)	ame of	DATE 20c, LOC	CATION -	City or Tow	n, State
4 Donetion 5 Other (Specify)	Hol	y Cr	oss Ce	nt.11/2	0/95 Bro	ook1	yn F	ark, Md.
21. BIONATURE OF PUNERAL SERVICE LA	TEMSEE		McCu.	nd address of fa 11y Fun	eral Home	alto 2,13	o ^{Md} .	21230 Fort Ave
23. PART , Enter the diseases, or shock, or heart feilure.	complications that caused the c List only one cause on sech ilr	deeth. Do n						Approximate interval Between
iMMEDIATE CAUSE (Final disease or condition	. pheumonic	2						Onset and Death
resulting in death)	DUE TO (OR AS A CONS							
	· ·		, _					
Sequentially list conditions,	b. AcuteMy o Condia			en				
if any, leading to immediate cause, Enter UNDERLYING	502 10 (011 NG X 001131	EGOENCE OF	1.					
CAUSE (Disease or injury	C. DUE TO (OR AS A CONSI	FOLIENCE OF	n.					
that initiated events reaulting in death) LAST	202 10 (011 A0 A 001101	EGOENOE OF	,.					i
	d							-
PART II. Other aignificant condition	a contributing to death but not	reaulting i	n the underlyin	g ceuse given in	Pert I. 24s. WAS AN		24b. 1	WERE AUTOPSY FINDINGS
PART II. Other algnificant condition					PERFOR	1 4		AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 🗆 YES 2	NNO		OF DEATH?
	DIDLITE TO CALICE OF DE	ATLL VE	c El No E	7 LINICEDTAN	V 53			1 TES 2 NO
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN			TH (Check only one)	UNCERTAI	N LZL I			
EXAMINER?	HOSPITAL:	1	OTHER;					
t ☐ YES 2 M NO 27. MANNER OF DEATN	1 X Inpatient 2 ER/Outpatient	_			6 Other (Specify)			
1 Natural 5 Pending	(Month, Day, Year)	28b. TIMI		URY AT	28d. DESCRIBE NOW IN	NURY OCC	CURED	
2 Accident investigation				YES 2 NO				
3 Suicide 6 Could not be	28e. PLACE OF INJURY — At h building, etc. (Specify)	home, farm, s	dreet, factory, offic	•	28f. LOCATION (Street a: City or Town, Stete)	nd Number	or Rural Ro	ute Number,
29e. CERTIFIER (Check only 1 CERTIFYING PNYS	ICIAN: To the best of my knowledge, o	death occurre	ed at the time, date	end place, end due	to the cause(e) end man	ner ee stat	ed.	
	R: On the besie of examination end/or							end manner se stated.
29b. SIGNATURE AND TITLE OF CERTIFIE				29c, LICENSE NUI				
	i. D.			AS 244	161436		C SIGNED !	Month, Day, Year) 1995
30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEATH (IT	EM 27) /5/04	Drint1				- 9	

Hospital

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SARKIS BOLISASIAN HOUSE

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospits	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Theodore King M.D.

31. DATE FILED (Month, Day, Year) NOV 2 1 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF OFATN YEAR 2:35 JAWAD K P AL-ABEDI 1995 NOV 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign DAYS 1 K M 2 F 31 JULY 1, 1964 579-25-3589 IRA0 9e. FACILITY NAME (If not institution, give street end number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 2400BLK. BROWN STATION ROAD UPPER MARLBORO PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY N/A WASHINGTON 1XX YES 2 ☐ NO D.C 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 101 ZIP CODE 1406 NORTH CAPITAL STREET 20002 IRAQ 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American indian, Black, White, etc. FORCES? 1 YES 2 If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried SpecifiARABIC 1 YES 2 X NO Specify. ВУ 3 Widowed 4 Divorced 15. OECEDENT'S EDUCATION COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mechanic Auto Repair 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) KADUM AL-ABEDI UNAVAILABLE BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 HARITH AL-ANI 205 YOAKUM PARKWAY #1503, ALEXANDRIA, VIRGINIA 22304 20a. METNOD OF DISPOSITION 1文文與uriel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State MARYLAND NATIONAL MEMORIAL PARK 11/13 4 Donetion 5 Other (Specify) LAUREL, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LIFENSIES 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 band the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fall ure. List only Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) HEAD AND NECK INJURIES DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AME ABLE PRIOR TO COMPLETION OF CAUSE XIX YES 2 NO TX YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL item **EXAMINER?** HOSPITAL OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 1 X YES 2 NO 4 Nursing Home 5 Residence XX Other (Specify) ROADWAY 6 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 🔲 Natural 5 Pending Investigation DRIVER IN ACCIDENT /1/1995 1307P^M 1 YES SUBJECT ВУ 2X Accident 28e. PLACE OF INJURY — building, atc. (Specify) Suicide At home, term, street, fectory, office 281. LOCATION (Street end Number or Rural Route Number, COMPLETED 8 Could not be ROADWAY 4 Homicide 2400 BROWN STATION ROAD item 29e. CERTIFIER (Check only I CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause (e) and manner is stated. RO ARYLAND (Check only one) = 🕉 XMEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner se stated NOV. 2, 1995 29c. LICENSE NUMBER 8 O.C.M.E 701 keodope 2

111 Penn Street, Baltimore, Maryland 21201

DHMH-18 Rev 1/89

31. DATE FILED (M.ZIII., Day, J. 1895

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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										5	15	349	18
1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND	/ DEPAR	TOTE O	F HEALTI	H AND	MENTAL	HYGIEL REG. NO				
1. DECEDENT'S NAME (F	rst, Middle, Last)							2. DATE (OF DEATH	DAY	YEAR	3. TIME OF DEA	
Kathleen B	rewer									Ĩ5	1995	05:14	A M
4. SOCIAL SECURITY NU		5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 Y		ER 24 HRS.	7. DATE (8. BIRT	NPLACE (State or F	oreign
218-30-917	/	1 M 2 K F	73	YRS.	MONTHS D	AYS HOURS	MIN.	Aug.	Day Year)	1922	Engl	land	
ge. FACILITY NAME (# no						WN OR LOCA		EATN			JNTY OF		
Washington		j Hospita	l		Hage	istown				wash	ringt	ton	
RESIDENCE OF D	10b. COUNT	TV .		10c CIT	Y. TOWN OR I	OCATION						10d. INSIDE CIT	v
Maryland		nington			gerst							LIMITS?	
10e. STREET AND NUMB					3	101. ZIP CO	DE			10a, CI	TIZEN OF	WHAT COUNTRY?	, NO
121 W. Ant		Street				2174						S.A.	
11. MARITAL STATUS		12. WAS DECEDER	NT EVER IN U.S.	ARMED	13. WAS	DECENDENT	OF NISPA	NIC ORIGIN	? (Specify Y	e or No-	14. RAC	CE — American Ind	llen,
1 Never Merried 2 3 Widowed 4 0		FORCES? 1	MAR OF WATES		If yo	YES 2 X N	ben, Mexic	en, Puerto R			Spe	CE — American Ind ck, White, etc. city:White	
15, 0	ECEDENT'S EDU		-	DECEDENT'S	USUAL OCCU	IPATION		16b.	KIND OF B	USINESS/IN	DUSTRY		
(Specify Elementary/Secondar	only highest grade	completed) College (1-4 or 5		(Give kind of life. Do NOT u	work done duri	ng most of wor	king						
12	(0-12)	College (1-4 of 5		ousewi	he								
17. FATNER'S NAME (First	, Middle, Last)				0 -	18. MC	TNER'S N	AME (First, N	fiddle, Maide	n Sumeme)			
Reginald B	ridger					Lo	uise	Brid	ger				
19a, INFORMANT'S NAM		(husband)		19b. MAILING	G AODRESS (S	-				wn, State, Z	(ip Code)		
John H. Br	ewer			121 W.	Antic	etam S	tree	t-Hag	ersto	wn, 1	lary	land 217	40
20e. METNOD OF DISPO	SITION RONG	ild Wade,	D COB PLAC	CE AND DATE	OF DISPOSITION	ON (Neme of		DATE	20c. L	OCATION -	- City or 1	Town, State	
4X☐ Donetion 5 ☐ Ot	her (Specify)	- 1	9.	crematory or									
21. SIGNATURE OF FUNE	RAL SERVICE L	ICENSEE ROMA	d wade	, Dir.	22. NA S T a	ME AND ADDI	TOM!	ACILITY Roam	d-655	(v) 7	Ralt	imore St	root
1000	11/1	1 Mare	le u	11/19								201-1559	
23, PART I. Enter the	diseases, or	complications the	et ceused tha	daath. Do								Approxir	_
/		. List only one ca	use on each I	Ine.								Onset ar	
disease or condition		500	0516									13 1	
resulting in death)		a. Sey	O (OR AS A CON	SEQUENCE (OF):							7 0	73
		b. Rec	tal	p.e	rfor	9+10	on					3 0	lay,
Sequantially list con if any, leading to im		DUE TO	OR AS A CON	SEQUENCE C	OF):								
cause. Entar UNDER	LYING	c.											
CAUSE (Disease or in that initiated evants		DUE TO	OR AS A CON	SEQUENCE (OF):								
resulting in death) L	AST	d											
PART II. Other signi	icant condition	ns contributing to	o death but no	ot resulting	in the unde	riving caus	a givan ir	n Part I.	24e. WAS /	IN AUTOPS	y 24	Ib. WERE AUTOPSY	FINDINGS
						,			PERF	ORMED?		AVAILABLE PRIO	R TO
								_	1 TYES	2 NO		OF DEATN?	
DID TOBACCO	TISE CON	TDIDLITE TO C	ALISE OF D	EATH V	ES TI NI) 107 LIK	ICERTA					1 YES 2	NO
25. WAS CASE REFERRE		T T			ATH (Check onl		1CENIA			_			
EXAMINER?		HOSPITAL:	☐ ER/Outpatien	4 3 D DO4	OTHER:	g Home 5 🗆	Dealdana	4 Oth-	· (Constitut				
27. MANNER OF DEATN		28e. DATE O		28b. Til		c. INJURY AT			CRIBE NOV	/ INJURY O	CCURED		
1 Natural 5	Pending	(Month,	Day, Year)	110	IJURY	WORK?	NO D	1					
2 Accident 3 Suicide	Investigation	28e, PLACE	OF INJURY - A	t home, ferm,				281. LOC	ATION (Stree	et and Numb	er or Rura	I Route Number,	
4 Nomicide	Could not be determined	building	, etc. (Specify)						or Town, Sta				
29e. CERTIFIER	EDTIEVING 5	BIGIANI, To the hear		al and b	and at the st			- 4a P			teste d		
(Check only		SICIAN: To the beet of NER: On the beele of										e(e) and manner or	hotete
				arrosagai	on, in my opii		Physical III		oro prece,				
29b. SIGNATURE AND TO	TLE/OF CERTIFI	ER .				29c. L	ICENSE NI	UMBER	1			ED (Month, Day, Yea	
10 NAME AND ADDRESS	A DEPOSIT	· XGn	W DE DE DEATH		o Christ'	$\perp \nu$	70	حام	1	1	FV	ember is	199
30. NAME AND ADDRES	S OF PERSON W	NO COMPLETED CA	USE OF DEATH	(ITEM 27) (Tvo	e. Print)								

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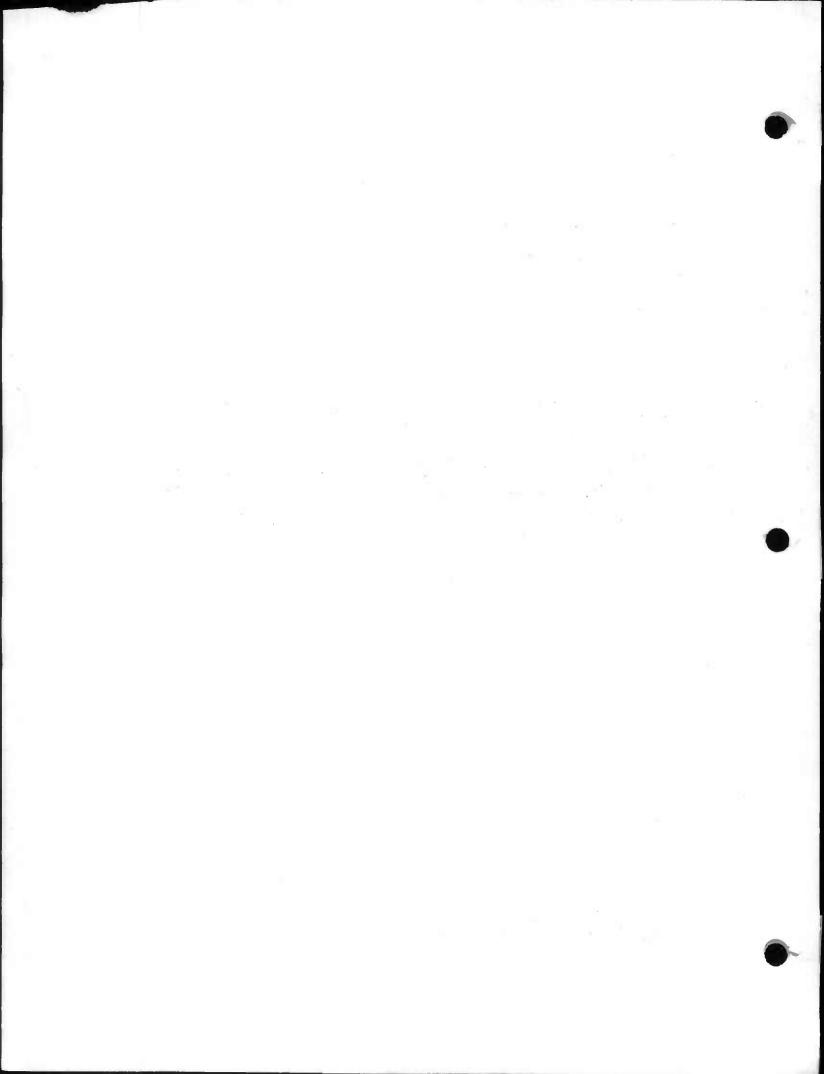
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or requires that the sentificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND I	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) PHYLLIS ANN BERE	ends				2. DATE OF DEATH NOVEMber	17 , 1995	3. TIME OF DEATH 3:26 A. M
	4. SOCIAL SECURITY NUMBER 219-32-6760		orthplace (State or Foreign entry) aryland					
TOR	Johns Hopkins Bayv	9c. COUNTY OF	DEATN					
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY Maryland N/A Baltimore							
FUNERAL	100. STREET AND NUMBER 719 S. Decker Avenue 100. STREET AND NUMBER 21224 U.							F WHAT COUNTRY?
BY								ACE — American Indian, ack, White, atc. White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S (Give kind of weither Do NOT us) Meat I	vork done during e retired.)	ATION most of working	Meat Pac	Alternative and the	
BE COM	17. FATNER'S NAME (First, Middle, Last) James Millar				The second secon	ME (First, Middle, Maiden & Loretta	Surname)	
0	19a. INFORMANT'S NAME (Type/Print) Miss Judy Berends	5				Baltimore	, Md. 2	
	20e. METHOD OF DISPOSITION XIX Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	oval from Stata Cem	etery, cremetory or of neland N	her plece) lemoria	(Name of 21 Park E AND ADDRESS OF FA	11-18 Bal	cation—city or ltimore	
	Dun S.	ratther	N	Matt	hews Fune	ral Home	ltimore	Md. 21224
	23. PART i. Enter the diseases, or cahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one caluse on e	ach iina.	+11		h ss cardiac or respir		Approximate interval Between Onset and Death
CERTIFICATION	Sequentisily list conditions, if sny, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initisted avanta resulting in dasth) LAST	a Rt AK	CONSEQUENCE OF	٨				5+7 8+7
AL	PART II. Other algnificant condition	s contributing to death b	ut not resulting	in tha underi	ying cause givan in	Part I. 24a. WAS AN APPERFORE 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YE			N 🗆		t YES 2 NO
YSICI	EXAMINER? 1 YES 2 AO	HOSPITAL: 1 Inpatient 2 ER/Outs	netlent 3 🗆 DOA	OTHER:	Iome 5 Residence			
ВУ РН	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY		M 1	INJURY AT WORK? YES 2 NO	28d. DESCRIBE NOW IN		
ETED	3 Suicide 8 Could not be determined	building, atc. (Spec	edy)			28t, LOCATION (Street a City or Town, State)		al Houte Number,
COMPLETED		CIAN: To the best of my know R: On the besis of examination						se(s) and menner as stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	à	~		29c. LICENSE NU	MBER 2 1	29d. DATE SIGN	IED (Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON WIN	7 1 1			-T Mg 2	121		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE					

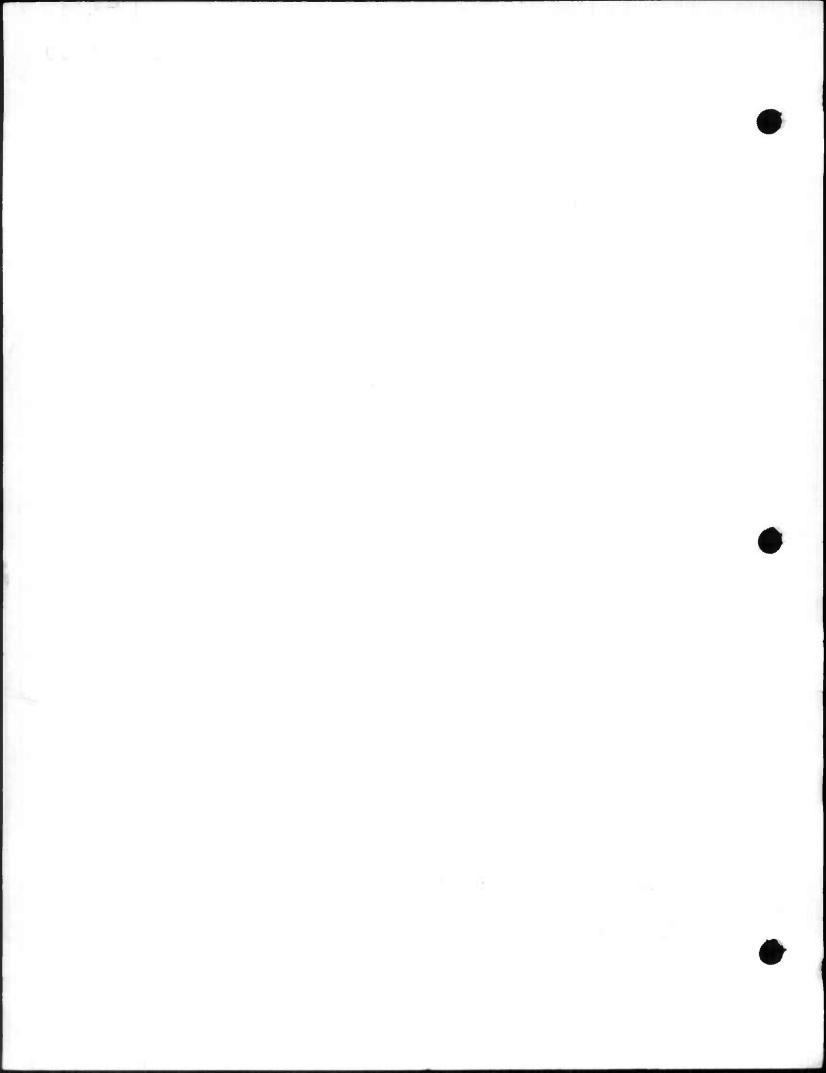
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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G PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	ing physician and completely filled in by the funeral direct giene prior to burial, cremation, or removal.
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cuted	sician and completely prior to burial, cremati
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cate t	by the attending physician and Mental Hygiene prior to
certifi	ding p
death	signed by the atten- lealth and Mental H
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W. T	his certificate has been signed by the with the State Dept. of Health and M.
YSIC!	s cert
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ENOIR	DR: After de
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TAL 0	IERAL OIRECTOR: After this certificate has been signed by the attending physician and in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bur
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STATE OF	MARYLAND / DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CERTIFICATE	OF DEAT	Н		REG NO

-	1	FOR STATE OF MARYLAND / DEPART CERTIFIC	MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.						
		1. DECEDENT'S NAME (First Middle, Last) Mildred Billy	7	2. DATE OF DEATH DAY S	1995 3. TIME OF DEATH					
	-	259-70-5 760 10 m2 MF 88 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. WONTHS DAYS HOURS MIN. 9b. CITY, TOWN OR LOCATION OF DE	7. DATE OF BIRTH (Month, Dey, Year) NOVEMBER 28, 190	8. BIRTHPLACE (State or Foreign Country) 7 G 4 4 4 4 4 A					
DIRECTOR		HESIDENCE OF DECEDENT	Baltimore		NA					
		ioc. ciri,	TOWN OR LOCATION I HM OVE 101, ZIP CODE	I ma c	10d. INSIDE CITY LIMITS? 1 YES 2 NO					
FUNERAL	ŀ	1404 Poplar Grove Street 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	2/2/6	Can IIC ORIGIN? (Specify Yea or No—	ada 14. RACE — American Indian.					
B≰	ш	1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES STATES	It yes, specify Cuben, Mexica 1 YES 2 NO Specify	n, Puerto Ricarı, etc.)	Specify: Black					
(PLETED		College (1-4 or 5+) // / / / / / / / / / / / / / / / / /	rk done during most of working	Home	NDUSTRY					
ed at once. BE COMPL		17. FATHER'S NAME (First, Middle, Lest) William Billy		ME (First, Middle, Melden Surname,	wn					
be notifi		198. INFORMANT'S NAME (Type/Print) Kath sen Hendy 1404 208. METHOD OF DISPOSITION 206. PLACE AND DATE OF	Poplar Gnue	St Balton	d 21216					
examiner must		1 Suriet 2 Cremeilon 3 Removel from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA	1/21/2 Kanda	Uls town, state					
odical exam	-	23. PART I. Enter the diseases, pr complications that caused the death. Do no	Mary F. H. U	labash Ave	Baltond					
vent, the med		shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Acute Renal Failure Due to (or as a consequence of): Decompensated Congestive Heart Failure Due to (or as a consequence of): Decompensated Congestive Heart Failure Due to (or as a consequence of): Decompensated Congestive Heart Failure Due to (or as a consequence of):								
or other traumatic e		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	ngertive thear	it Failure	Years					
rs any EDICA		PART II. Other significant conditions contributing to death but not resulting in	tha underlying cause given in	Part I. 24a. WAS AN AUTOPS PERFORMED 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
d, or item 23 shov HYSICIAN: M		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 20. PLACE OF DEATH		10	1 TYES 2 PNO					
od, or ite PHYSIC		1 VEC 1 FUID	OTHER: Nursing Home 5 Residence 28c. INJURY AT	6 Other (Specify) 28d. DESCRIBE HOW INJURY O	COLORD					
6 C		1 Netural 5 Pending (Month, Dey, Year) INJUI 2 Accident 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, farm, str bullding, etc. (Specify)	M 1 YES 2 NO	281. LOCATION (Street and Numb						
If item 28 IPLETE	-	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred								
TO BE CON	L	29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P	DH13	8ER 29d. 04	Toverber 15, 1995					
	3	George E. Wicks III M.D. 26	00 Liberty H.	eights Ave	21215					
	L	NOV 2 1 1995 Sale Divelege lands								



	1 - STATE REGISTRAR	SIMIE UF I		RTIF	ICATE C			MENIAL HYGIEI REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH	DAY	3.	TIME OF OEATH
	Elvina E. Bunn	iell						Nov. 17,	1995	YEAR 1	1:15 A
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 YEA		R 24 HRS.	7. DATE OF BIETH	1942	B. BIRTHPLA Country)	ACE (State or Foreign
	217-38-7964	1 - M 2 XF	53 54	YRS.	MONTHS DAT	8 HOURS	Milly,	March 24	1041	Maryl	and
_	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TOV	N OR LOCAT	ION OF DE	EATH	9c. COUN	TY OF DEAT	н
ОН	4514 Forest View	Avenue			Balti	more				N/	A
DIRECTOR	10e, STATE 10b, COUNTY			10c. C/1	Y, TOWN OR LC	CATION				10.	d, INSIDE CITY
E	Maryland N/A			150. 01.	Balti						LIMITS?
	10e. STREET AND NUMBER				bacci	101. ZIP COI	DE		10a CITIZ		T COUNTRY?
HA.	4514 Forest View	Anamua						1206		•	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. ARI	AED	13, WAS	DECENDENT		I Z U O NIC ORIGIN? (Specify Y	ee or No-	U.S.	American Indian,
B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1	MAR OR DATES	0	If yee		en, Mexice	n, Puerto Ricen, etc.)		Black, W	white
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DEC	CEDENT'S	USUAL OCCUP	ATION most of work	dna	16b. KIND OF B	USINESS/IND	USTRY	
<u>-</u>	Elementary/Secondary (0-12)	College (1-4 or 5	- Hin	Do NOT u	se retired.)						
MP	12th grade		Sale	SR	epreser	_		Bank			
8	17. FATHER'S NAME (First, Middle, Last)							AME (First, Middle, Meide			
BE	Harry L. Ecclesto	n Sr.	Lan					y McKeeve			
5		Th 10.			Service of the service of			Route Number, City or To			002
	Robert W. Vickers 200. METHOD OF DISPOSITION				OF DISPOSITION		ва	etimore. 1	OCATION —	nd ZI	093
	1 Buriel 2 Cremetion 3 Remo	ival from State					11/2	0/95 Bal			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1 1					eral Home		-,	, , , , , , , , , , , , , , , , , , , ,
	· Pobert J.	hodal	//_	_	9705	Bela	ir R	d., Baltimo			36
	23. PART I. Enter the diseases, or c shock, or heart fellure. I	omplications the	at coused the decuse on each line.	eth. Do	not enter the	mode of d	ying, auc	h as cerdlec or rea	piratory arr	eat,	Approximate Interval Between
	IMMEDIATE CAUSE (Fine)	1 :	n .i								Onset and Deal
	disease or condition resulting in death)	Hyper	DI TUD	IN-	mia						140
		Λ .				r					
NO N	Sequentially list conditions,) TOP	O OR AS A CONSEC	CIENCE C	remoli	1515					145
AT	if any, leading to immediate cause. Enter UNDERLYING	1				•					2 4
필	CAUSE (Disease or injury that initiated events	DUE TO	O OR AS A CONSEC	UENCE C	F):						- 91
CERTIFICATION	resulting in deeth) LAST	Alco	hot a	hu	5-8						345
	PART ii. Other significent condition	a contribution to	death but not e	a au del mar	In the under	ulma acusa	aluan In	Part I as una	N. ALITTORON		
ICAL		s contributing to	death but not n	eauring	in the under	ying ceuse	given in	PERF	N AUTOPSY ORMED?	AM	ERE AUTOPSY FINDING: AILABLE PRIOR TO EMPLETION OF CAUSE
	Depression							1 YES	2 NO		DEATH?
MED	DID TOBACCO USE CONTR	DIDLITE TO CI	TICE OF DEV	TLI V	ES I NO	I⊠ LINI	CERTAI	N.D.		11	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	IIBUTE TO CA			TH (Check only		CERIAI	N L			
S	EXAMINER? 1 YES 2 NO	HOSPITAL:	☐ ER/Outpetient 3		OTHER:			6 T 6 to 10 to 11			
H K	27. MANNER OF DEATH	28e. DATE OF		28b. TII		INJURY AT	rieeldence	8 Other (Specify) 28d. DESCRIBE HOW	/ INJURY OCC	URED	
	1 Natural 5 Pending Investigation	(Month, E	Day, Year)	IN	JURY M 1	WORK? YES 2	□ NO				
Э ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e, PLACE (OF INJURY — At hor	me, ferm,	street, fectory,	office		281. LOCATION (Street		or Rural Rout	Number,
E	4 Homicide datermined	Dunuting,	, etc. (Specify)					City or Town, Star	10)		
J.E	290. CERTIFIER (Check only	CIAN: To the best o	f my knowledge, de	oth occur	red at the time,	date end place	ce, end due	to the cause(e) end m	enner ee stat	ed.	
COMPLETED	10000000000							time, date end place,			nd menner ee stated.
C	296. SIGNATURE AND STILE OF CERTIFIER					29c. L/	CENSE NU	MBER	29d. DATI	E SIGNED (M	onth, Day, Year)
0	Johnson	-mo)			1	92:4		D11	120	195
٩	30. NAME AND ADDRESS OF PERSON WHO	9000 F	SE OF DEATH (ITEM	127) (Typ	re Dr	è. (Bul	t. MD	,	1	
	31. DATE FILED (MONTH Day, Year). NOV2 1 1995	Per da	AR'S SIGNATURE	16					_		

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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PITAL OR ATTE	"RAL DIRECTOR:	nin 72 hours after

	1		PARTMENT OF HEALTH AND N	MENTAL HYGIENE REG. NO.	
		NULLE O. Blolts		2. DATE OF DEATH DAY NONTH DAY	GYEAR 9:55 AM
2			YRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OC+ 14, 19 16	6. BIRTHPLACE (State or Foreign Country) Md
2. 3 should		NI DENTY MEDICAL CENTER NESIDENCE OF DECEDENT	Baltimore	ATH 9c. COL	NA NA
t. Pages 1, 2, 3. DIRECTOR		T T	Baltimore		10d. INSIDE CITY LIMITS? 1 YES 2 \(\bar{\text{\tinx{\text{\titt{\texi{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\titte{\text{\tilit}\\text{\text{\text{\text{\tinit{\text{\text{\text{\text{\texi{\text{\texi{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texi{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\tex{\texit{\titt{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\ti
20 vysician. urial-transit permit. FUNERAL D		4508 White Oak Avenue	101. ZIP CODE 21215	10g. CIT	IZEN OF WHAT COUNTRY?
-0020 ing physician. the burial-transit BY FUNER		I. MARITAL STATUS Never Married 2 M Married Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES	13. WAS DECENDENT OF HISPAN If yee, specify Cuben, Mexicar 1 YES 2 NO Specify	n, Puerto Rican, atc.)	14. RACE — American Indian, Black, Whita, atc. Specify: Bladk
100 77	- 11	(Specify only highest grade completed) (Give in	DENT'S USUAL OCCUPATION uind of work done during most of working NOT use retired.)	Social S	
LAND 21215 the hospital or attent detached for use as once.		7. FATHER'S NAME (First, Middle, Last)		ME (First, Middle, Meiden Surname)	curity
MARYLAND retained by the hospit stood by the detached notified at once. TO BE COMPI	-	10. A O A.	AILING AODRESS (Street and Number or Rural F	1 0 11	1
60 00		Qe. METHOD OF DISPOSITION Burlel 2 Cremetion 3 Removal from State Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, cremate Committee, committee, committee, committee, committee, committee, cremate Committee, commit	DATE OF DISPOSITION (Name of ory or other place)	DATE 200 LOCATION -	Office of Town, State
BALTIMORE, ar death. Page 6 may b the funeral director, page val.		1. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FAI March F. H.	out west	2/2/5
in by remo		23. PART I. Enter the diseases, or complications that caused the daeth shock, or heert failure. List only one cause on each line.	. Do not antar the mode of dying, such	h se cardiac or respiratory s	rreet, Approximats interval Between Onest and Daeth
tely fille mation,		MMEDIATE CAUSE (Fine) Idease or condition esulting in death) DUE TO (OR AS A CONSEQUE	alure		Onest silu Daetii
P 8 8 8		Sequentially list conditions, f sny, leading to immediate	epulentius		
四 2 4 2 2		cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	ng opathy	l DW Farct	
D When the Injury		PART II. Other significent conditions contributing to death but not rest			
				1 YES 2 100	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
W Saper		EXAMINER? HOSPITAL:	OTHER	N I	
0 4 2 4 .		1 Natural 5 Pending (Month, Day, Year)	DOA 4 Nursing Home 5 Residence 8b. TIME OF NURY AT WORK? M 1 YES 2 NO	6 Other (Specify) 26d. DESCRIBE HOW INJURY OF	CCUREO
SION FENDING OR: After frer death frer death		2 Accident Investigation 3 Suicide 6 Could not be determined local determined 26a. PLACE OF INJURY — At home, building, etc. (Specify)		261. LOCATION (Street and Numb City or Town, State)	er or Rural Route Number,
Z Z = Z		99. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation.			
PORT THE POR	3	SOL BIONATURE AND TITLE OF CERTIFIER	29c. LICENSE NUI		LIE SIGNED (MONTH, Day, Year)
V ₀ ,/0 = 22 €		TO TONICE LY LAWS	100.	te, Baltm	me. md 21215
		NOV 2 1 1995 1. Assistant Signature	9		

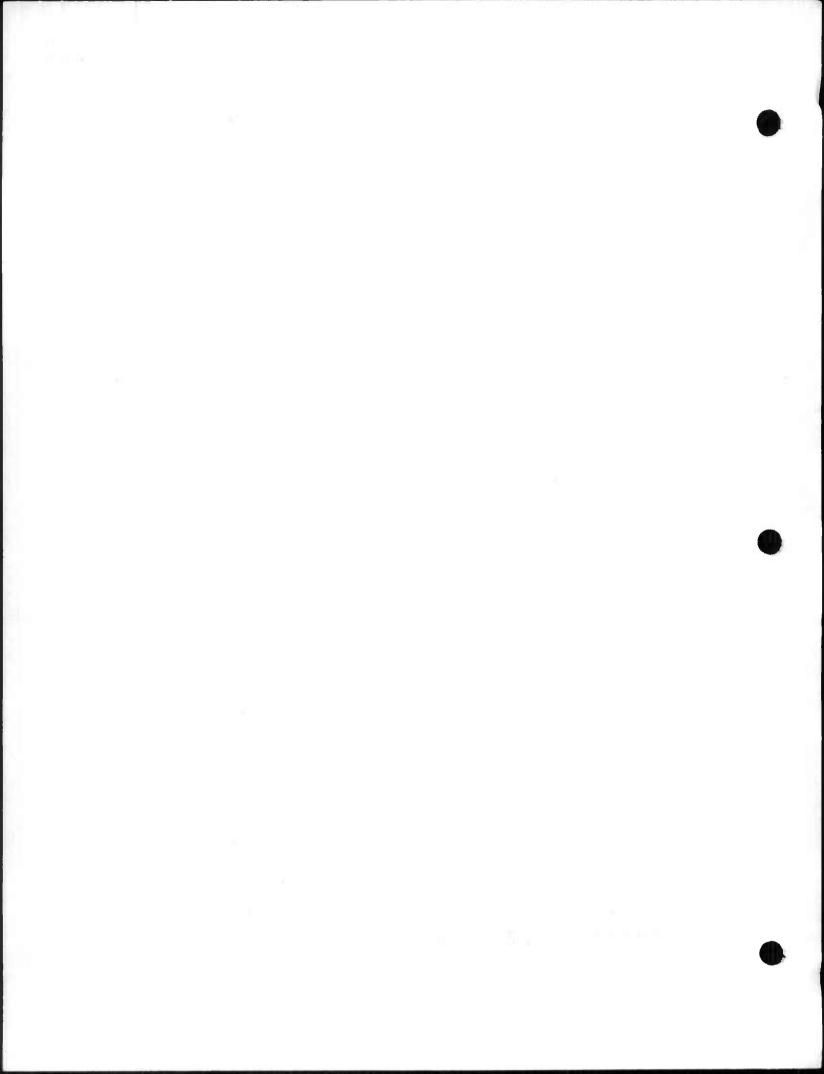
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG, NO.								
	1. DECEDENT'S NAME (First, Middle, Last) Chay Les	E BRO	oZ.					EAR	NE OF DEATH
	218-07-9664	1 M 2 □ F 74	Vec N	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MARCH 5	1921	BIRTHPLACE Country) Mary 1	(State or Foreign
e G	90. FACILITY NAME (If not institution, give stre Anne Arundel M RESIDENCE OF DECEMENT				BLOCATION OF DE		9c. COUNTY OF DEATH Anne Arundel		
FUNERAL DIRECTOR	10s. STATE 10b. COUNTY	e Arundel	10c. CITY,	Arnol				L	NSIDE CITY IMITS? YES 2 X NO
ERAL	10e. STREET AND NUMBER 570 Bellerive R				ZIP CODE 21012		10g. CITIZEN		
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO		ENDENT OF HISPAI	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)		RACE — Am Black, White	erican Indian, o, etc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use)	k done during mo retired.)	N at of working	16b. KIND OF BU			
MO	17. FATHER'S NAME (First, Middle, Last)		Mechai	110	18. MOTHER'S NA	ME (First, Middle, Malder	ng Mac	rme	
BEC	Joseph	Br	`OZ		Ann		Werr	ner	
2	190. INFORMANT'S NAME (Type/Print) John L. Wisthoff					Route Number, City or Tox			
	20s. METHOD OF DISPOSITION 1 Burisl 2 A Cremation 3 Remov		PLACE AND DATE OF			sadena, Md	. 21122 DCATION — City		
	1 Donation 5 Other (Specify)	val from State cerre	letro Crer				1timore		
	21. SIGNATURE OF FUNERAL SERVICE LIGHT	ENSEE .		Stall 3111	ngs Fundantain	eral Home Rd. Pasad	PA ena. Mo	d. 211	
PHYSICIAN: MEDICAL CERTIFICATION	advantile applic and character and and performed?							24b. WERE AMAILA	AUTOPSY FINDINGS BLE PRIOR TO LETION OF CAUSE ATTH?
AN:	DID TOBACCO USE CONTRI				UNCERTAIL	N		1 🗆 Y	ES 2 NO
SIC	EXAMINER?	HOSPITAL:		THER:	S [] Bealdana	6 Other (Specify)			
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	286. TIME (OF 28c. INJI	JRY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED	
						imber,			
29e. CERTIFIER (Check only one) 29m. MEDICAL EXAMINER: On the beets of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as at the control of the cause of the c								euse(e) and m	enner as stated.
IO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OF	, W. D.	int) -	Dary	31	29d. DATE SIG	12-99	5
		SCHUH, NU	10 60		dgely	Aus. A	nnago	115 2	21401
	MUV2 17995	in division to	dell						



IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be seen with the State hear of Health and Mental Hydiele prior to burial, cremation, or removal.	or item 23 shows any injury, or other traumatic event, the m
TO THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL OIRECTOR: After this ce	IMPORTANT: If Item 28 is marked,

12

	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE OF MARYLAND / DEPARTMENT OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)	BLEY							6:34 pm		
	4. SOCIAL SECURITY NUMBER 216-01-0133	1 □ M 2 😿 F	(In yrs. last birthday) 91 YRS.		DAYS HO	UNDER 24 HRS.	Jul	of BIRTH b, Day, Year) Ly 3,19	004 Ma	iryla	
SR	9a. FACILITY NAME (If not institution, give s Saint Joseph Med					ocation of de					
5	RESIDENCE OF DECEDENT										
DIRECTOR		cimore	10c. CI1	Glen Arm							. INSIDE CITY LIMITS? YES 2 X NO
FUNERAL	100. STREET AND NUMBER 11630 Glen Ar	m Rd.		101. ZIP CODE 21057				10g. CITIZEN	S.A.		
Ξ	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. W	WAS DECEND	CENDENT OF HISPANIC ORIGIN? (Specify Yes					
BY FL	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	FORCES? 1 YES 2 NO If yes			ss, specify Cuban, Maxican, Puario Rican, etc.) YES 2 XNO Specify:			Specify: White		nite, atc.
TED	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done di	CUPATION luring most of	working	16b	. KIND OF BUS	INESS/INDUST		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		etary				State	e Government		
BE CO	17. FATHER'S NAME (First, Middle, Last) Charles	Abı	cams		18.	Sarah	ME (First,	Middle, Maiden	Surname) Hami1 t	on	
TO B	Dennis Hawkins					umber or Rural Tows					
	20e. METHOD OF DISPOSITION 10 Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other place) 1 Date 1 Location - City or Town, State 1 Corraine Park 1 Location - City or Town, State 1 Corraine Park 1 Location - City or Town, State										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell—Wiedefeld Home Inc 6500 York rd. 21212							750				
	IMMEDIATE CAUSE (Final	List only one cause on a	asch iina.	not enter	the mode	of dying, suc	ch as can	diac or respi	ratory arrest	26	Approximate Interval Between Onset and Death 1 HOUR
	disease or condition resulting in death) CARDIAC ARREST a. Due to (or as a consequence of):									IIIJOK	
NO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (DISEASE (DISE										1 hour
CATI											
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):								,	
AL CE	PART II. Other significant condition	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS									
DIC							_	PERFOR	X	co	MPLETION OF CAUSE DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONT	RIBUTE TO CAUSE (OF DEATH Y	ES 🗆 N	10 🗆	UNCERTAI	N \square			1(YES 2 THO
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DE	-							
YSIC	1 TES 2 NO	HOSPITAL: X 1 Inpatient 2 ER/Out	tpatiant 3 🗆 DOA	OTHER 4 - Nurs		5 🗆 Rasidenca	s 🗆 Oth	er (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. Ti	ME OF JURY M	28c. INJURY WORK?	2 NO	28d. DE	SCRIBE HOW I	NJURY OCCUR	ED	
red BY	2 Accident Investigation 3 Suicide S Could not be 4 Homicide datermined	28a. PLACE OF INJUR building, atc. (Spr	LACE OF INJURY — At home, farm, street, factory, offica utilding, atc. (Specify)					Rural Route	Number,		
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
	29b. SIGNATURE AND TITLE QE CERTIFIE					C. LICENSE NU					onth, Day, Year)
TO BE	Michellia				-	D446			▶ 11	19/9	
F	30. NAME AND ADDRESS OF PERSON WIND MICHAEL SUTER, I	M.D., 6701 NO	RTH CHA	RLES	STREE			E, MARY	(LAND,	21 204	
	31. NOV2 1 1995	32. REGISTRAR'S SIG	NATURE								

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HC	TO THE FU	be filed wit	IMPORTA

4	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEOENT'S NAME (First, Middle, Last)	20SS BLA	TT			2. DATE OF GEATH DANNING IN	7, 1995	3. TIME OF OEATH S:30 PM		
	4. SOCIAL SECURITY NUMBER 216-28-2323	1	5. SEX 6. AGE (In yrs. last birthday) IF UN			7. DATE OF BIRTH (Month, Day, Year) Jan. 12,1	8. Bi	RTHPLACE (State or Foreign unity) laryland		
5	90. FACILITY NAME (If not institution, give sinai Hospital	9		timore	ATN	F DEATN				
DINECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNT Maryland N/		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? NX YES 2 NO			
	10e. STREET AND NUMBER	A	Da.	ltimore	. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?		
CINCLINE	7207 Brook Cres	12. WAS DECEDENT EVER	IN U.S. ARMED			IIC ORIGIN? (Specify Yes	or No.— 14. R	S.A.		
	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? XX YES IF YES, GIVE WAR OR C WW II			ecify Cuben, Mexical 2 X NO Specify	n, Puerto Rican, stc.)		pecity: White		
	15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	life. Do NOT use i	rk done during mo retired.)	ON ast of working	16b. KIND OF BU				
	12 17. FATNER'S NAME (First, Middle, Last)		Salesma	an	18. MOTNER'S NAI	Furnitu ME (First, Middle, Maiden		pliance		
. 11	Hyman	Gr	ossblatt		Est			known		
2	19e. INFORMANT'S NAME (Type/Print)			ODRESS (Street		Route Number, City or Tow				
*	Mrs. Ida Grossbl				est Way			e, MD 21208		
	20e. METNOO OF DISPOSITION 1 Suriel 2 Cremetion 3 Ren 4 Donetion 5 Other (Specify)	noval from State CR	b. PLACE AND DATE OF metery, cremetory or othe clington—	r place)			Baltimo			
8	21. SIGNATURE OF FUNERAL SERVICE U	-	LITINGCON	22. NAME A	Levinson	n & Bros.				
_	23. PART I. Enter the diseesea, or	NOR	ww					e, MD 21215		
		List only Dna ceuse on	aech line.			ir aa ourdroo or reap	matory untoot,	Interval Batween Onset and Death		
2	disease or condition a. AMMC Cardinama 24days Jue to (or as a consequence of): Due to (or as a consequence of): Cardinama Cardinam									
NO LEGITALISME	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events oue to (or as a consequence of):								
מכאר כר	PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. PERF							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH?		
MEDIC	DID TOBACCO USE CON	TRIBUITE TO CALISE	OF DEATH VEG	M NO F	UNCERTAIN			1 TYES 2 NO		
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)	1.00					
PH TSICIAN:	1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending	1 Inpstient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year)	/ 28b. TIME	OF 26c. IN	JURY AT DRK?	6 Other (Specify) 26d. OEŞCRIBE NOW	INJURY OCCURE	D		
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined	26e. PLACE OF INJUIS	RY — At home, farm, streedly)			281, LOCATION (Street City or Town, Stells		ural Route Number,		
COMPLEIED	Crieck Only	SICIAN: To the best of my kno						use(a) and manner as stated		
20 20	29b. SIGNATURE AND TITLE OF CERTIFI		micel	1. lea	29c. LICENSE NUI AJ414 3		4	INED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERIOD W	NO COMPLETED CAUSE OF C	DEATH (ITEM 27) (Type, F	Print)	Denach	2677	10000	halfund Me		
	31. PATE FILED (Month 1995)	REGISTRAR'S IG	SNATURE	1100	, IVCVONT	micon of J	myery,	DOLLIS WYON - , IVWY		

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

3. TIME OF DEATH

REG. NO.

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2. DATE OF DEATH MONTH DAY DAY YEAR NOVENBEL 15 1995 AMIDE! AKE 2:25 A. 4. SOCIAL SECURITY NUMBER 6. AGE (in vrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) MAR. 23, 1914 213-10-3387 1 M 2 - F DAYS HOURS 81 MARYLAND completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rial, cremation, or removal. 9e. FACILITY NAME (If not institution, give street and number) 96, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR SINAI HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? 10e. STATE MARYLAND BALTIMORE BALTIMORE 1 TES 2X NO 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 100. STREET AND NUMBER 6659-B SANZO ROAD 10f. ZIP CODE 21209 USA 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 27 NO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify BY 3 Widowed 4 Divorced WHITE COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 pr 5 +) 12 PROPRIETOR AUTOMOBILE SALES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) T **EDWARD** BLAKE DORA 띪 KLIER notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. DINA BLAKE 6659-B SANZO ROAD BALTIMORE, MD 21209 pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Nama of 20c. LOCATION - City or Town, State DATE must 1 & Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (\$\text{Poecify}) BETH EL MEMORIAL PARK - 11-16-1995- RANDALLSTOWN, examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE MD 21215 medical 23. PART I: Enter the diseases, or ophipications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, ehock, or heart feliure. Liet only one ceuee on each line. Approximate intervei Between Onset and Death IMMEDIATE CAUSE (Final the diseese pr condition_ Renal Failure
Due to (or as a consequence of): 24hr resulting in death) traumatic event, Schemic Chardlomyopathy prior to burial, CERTIFICATION and Sequentially list conditions, if any, leading to immediate has been signed by the attending physician Dept. of Health and Mental Hygiene prior to DUDINAN ALLEY disense
DUE TO (OR AS A CONSEQUENCE OF): ceuse. Enter UNDERLYING CAUSE (Disease Dr Injury or other thet initiated events resulting in death) LAST Injury, PART II. Other significent conditione contributing to deeth but not recuiting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL PAVKINSON'S Disease shows any 1 - YES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\sigma \) NO \(\sigma \) UNCERTAIN \(\sigma \) PHYSICIAN: 23 26. PLACE OF DEATN (Check only one 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Item State HOSPITAL:
1 Ninpatient 2 ER/Outpatient 3 DOA certificate OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 0 with the 27, MANNER OF DEATN 28e. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, This 1 Netural 5 Pending м 1 YES 2 NO BY 2 Accident Investigation After death 28e. PLACE OF INJURY — At home, term, street, tectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide : FUNERAL DIRECTOR: Af I within 72 hours after of RTANT: If Item 28 Is 28 is 8 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER (Check only one)

2 MEDICAL EXAMINED: On the best of assemble to the course of the lime, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end menner ee stated. MPORTANT 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER THE P BE 452402321RD9711 NOVEMBER 15,1995 Rolin G. Davis, MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 223 9 2401 W. BELVEDERE AVE RATINORE MD 21215

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

er o Jane of BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

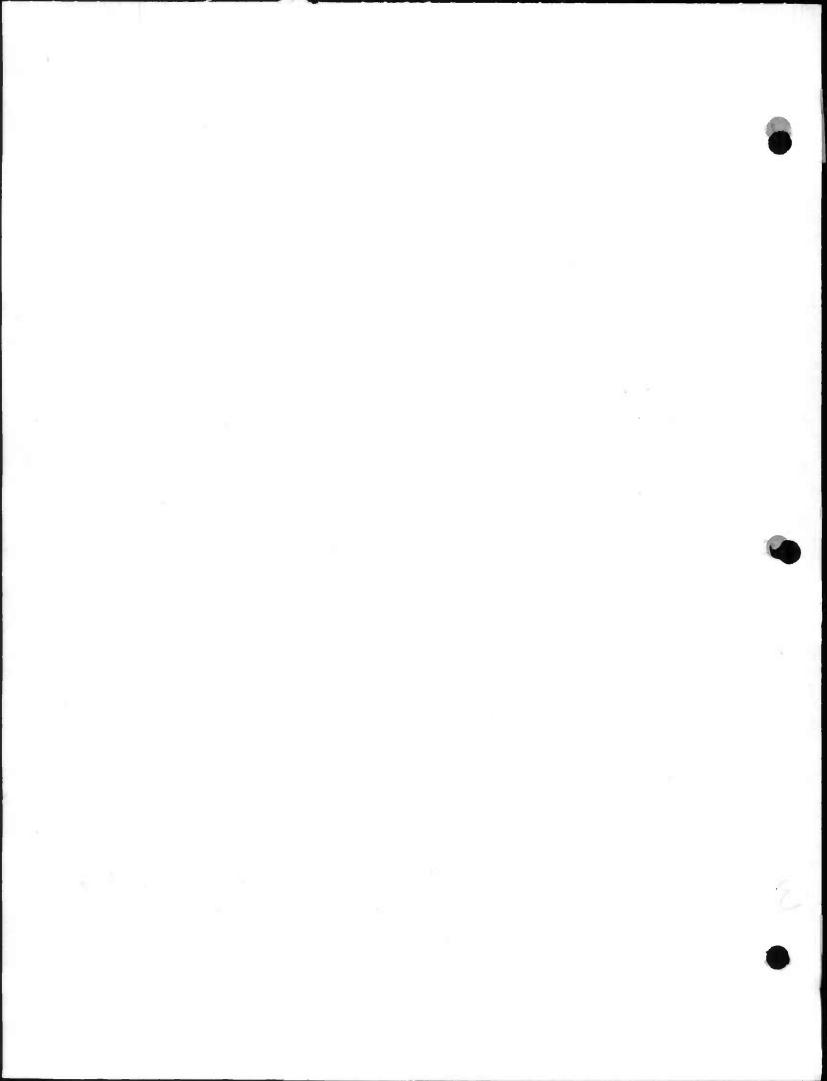
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

_	TIEGIOTIAN				OLIVIII	IVALL		DLA	111		HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, List) CATHERINE BAST 2. Date of Death Month Day 16, 1995 4:42 P. M													
		ATHERI	INE E	BAST						NOVE	ember "	16.19	995°	4:42 P. M
- 1	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In vr	s. last birthday	IF UNDER	1 VEAR	IF UNDER	24 HBS	_	OF BIRTH			PLACE (State or Foreign
	213 10 51	32	1 M 2 XF	101	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	Dev. Year)		Countr	V)
											06 94	Maryland		
	9a. FACILITY NAME (If not institution, give street and number)							OR LOCATI	ON OF DE	EATH			NTY OF D	EATN
5	Bay View	Hospit	al			Baltimore N/A								
DIRECTOR	RESIDENCE OF DECEDENT													
<u> </u>	10a. STATE					CITY, TOWN OR LOCATION							10d. INSIDE CITY	
5	N/A B					altimore					LIMITS? 1 X YES 2 NO			
	10e. STREET AND NUMBER						10	1. ZIP COD	E		10g. CITIZEN OF WHAT COUNT			
2	821 South Eaton Street					21224					USA			
FUNERAL														
2	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1								or No-	14. RACE Black	— American Indian, , Whita, atc.	
BY	1 Never Married 2 Married IF YES, GIVE WAR OR DATES 3 VWidowed 4 Divorced							2 X NO			, 0.0.,		Whit	
	3 [X mooned 4 Divo	TOOU				l							wnit	e
		EDENT'S EDUC highest grade		164	Give kind o	S USUAL O	CCUPATI	ON of worki	200	16b.	KIND OF BUS	SINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0		College (1-4 or 5	+)	Iffe. Do NOT	use retired.)	dunny me	OSE OF WORK	ng		-			
4	Unknown	.			House	work					At	Home	5	
Σ	17. FATHER'S NAME (First, M	icicle. (.ast)			16. MOTHER'S NAME (First, A					Siddle Maiden	Cumpmal			
	Ernest F									Sepha		Jonanne)		
H H										_				
5	19a. INFORMANT'S NAME (1) Ruth Balling	ype/Print)			19b. MAILIN	G ADDRES	S (Street i	and Number	r or Rural I	Route Numl	per, City or Tow	n, State, Zi	p Code)	
-	Much Dallin	3			021 6	s. La	COU	Stre	et E	sarto	.,Md.	2122	.4	
	20a. METHOD OF DISPOSIT			20b. PL/	ACE AND DATE	OFDISPOS	SITION (Name of DATE 20c. LOCATION — City or Town, Start				wn, State			
	1 Burlai 2 Crematio		oval from Stata	cemeter)	y, crematory or	other piece)					БМ			
1	1 Several 2 Cremetion 3 Removed from State 4 Donetion 5 Other (Specify) Sacred Heart of Jeusus Cem 11-18-95 Dundalk, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE													
	- n	1	In 17	- 1							& Son	Tnc		
	har	len	U.	jeur	\sim						t. Bal			
	23. PART I. Enter the d	seeses, or o	complications the	t ceueed the	e death. Do	not enter	the mo	ode of dy	Ing. suc	h as cere	lec or reap	ratory ar	Teet.	Approximate
	ehock, or h	eert fallure.	Liet only one cau	use on each	line.								1000	Interval Between
	IMMEDIATE CAUSE (Fir disease or condition	ne i	6	11 -	0	_	. 1		-	00.				Onset and Death
	resulting in death)													
	DUE TO (OR AS A CONSEQUENCE OF):													
z	Sequentially list and dillow													
2	Sequentially list conditions, If any, leading to immediate													
٩	cause. Enter UNDERLYING													
HIFICATION	CAUSE (Disease or Inju	LY .		(OR AS A CO	NSEOUENCE	OF):								
=	resulting in death) LAS	T												
<u> </u>			d											
	PART II. Other eignifice	nt condition	e contributing to	death but r	not reeuiting	In the ur	nderlyln	g ceuse	given in	Pert I.	24a. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS
EDICAL	CEREL	BROV	ASCUL	AR	ACC	1DE	NY	•			PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
5											1 YES 2	NO		OF DEATH?
Ž													1	1 TES 2 0 NO
	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF D	DEATH Y	ES 🔲	NO [JUNG	CERTAIL	N 🗆				
SICIAN	25. WAS CASE REFERRED TO	O MEDICAL		28. 1	PLACE OF DE	ATN (Check	only one)							
2	EXAMINER?		HOSPITAL:	FR/Outpation	M 3 1 000	OTHE			- ald- · ·		- 10			
2	27. MANNER OF DEATH		28a. DATE OF						esidenca	6 Othe		A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1	MA LECT	
<u> </u>	ed	Pending	(Month, C		28b. Ti	NE OF	W	JURY AT DRK?		28d. DES	CRIBE HOW I	NJUHY OC	CURED	
À		Investigation		_		М	1 🗌		NO .					
- 0		Could not be	26e. PLACE C	of INJURY - / atc. (Specify)	At home, ferm	, street, fac	tory, offic	ca			ATION (Street in		er or Rural F	loute Number,
2	4 Homicide	detarmined								Unity 1	or rown, order,			
" "	29a. CERTIFIER 1 SC CERT	IEVING PHYSI	CIAN: To the heet of	l mu knowlede	a danth assur		4				· (2) - (3) (4)			
COMPLE			CIAN: To the best of											
5	Z MED	CAL EXAMINE	H: On the besis of a	ixamination en	d/or investigat	ion, in my	opinion, o	death occu	red at the	time, data	end place, an	d due to t	he cause(s) and manner as stated.
	296. SIGNATURE AND THLE				^			29c. LIC	ENSE NUI	MBER		29d. DA1	TE SIGNED	(Month, Day, Year)
ן מ	KN110	money	any,	NE	D.			1)1	7.7	-3-3		•	11-	20.95
	10//20													7
2	30. NAME AND ADDRESS OF			SE OF DEATH	(ITEM 27) /E-	no Printi								
2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEATH	(ITEM 27) (Typ	e, Print)	RIM	0.7	. 72	ALT	AND AND		1 0	1225
2	K.S. DH	F PERSON WH	O COMPLETED CAU ASENA , N	n.0.	710	C Hul	RCH	ST	· 31	ALT	in bre	, Mj	2	1225
2	K · S · D H 31. DATE FILED (Month, Day,	F PERSON WHI	O COMPLETED CAU ASEN A , N	n.0.	710	c Hul	RCH	51	· 31	ALT	in bre	, Mi	2	1225
2	K.S. DH	F PERSON WHI	O COMPLETED CAU ASEN A , N	n.0.	710	oe, Print) CHUF	RCH	ST	· 31	ALT	in bre	, Mi	0 2	1225



FOR STATE REGISTRAR

SAMUEL

1. DECEDENT'S NAME (First, Middle, Last)

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VIAL RECORDS, F.O. DOA SE	law requires that the death certificate be ex
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4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 1# M 2 | F DAYS HOURS 239 32 5937 72 9a. FACILITY NAME (If not institution, give street and number, 96. CITY, TOWN OR LOCATION OF DEATN DIRECTOR Pages 1, 2, 3 (HOME) 447 OXFORD CT. BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY MD. BALTO. CITY BALTIMORE permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 447 OXFORD CT. 21201 bunal-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO ath. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 21 NO Specify: 11. MARITAL STATUS FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2# Married BY the 3 Wildowed 4 Divorced use as 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done life. Do NOT use retired.) ᇤ Por Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL CONTRACTOR 12 page 5 should be detached notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) WILLIAM BAILEY LILLIAN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Boute Number City or Town, State, Zip Code) **DELORES** 447 OXFORD CT. BALTIMORE, MD. 21201 BAILEY 90 20a. METHOD OF DISPOSITION 20h PLACE AND DATE OF DISPOSITION (Name of 20s. METHOD OF DISPOSITION

1# Burlal 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) must funeral director, MT. ZION CEM. 11/20/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSIE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 FUTAW PL. BALTO, MD. 21217 in by the the medical 23. PART L Enjer the diseases, or complications so not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. Liet only one can 6 filled IMMEDIATE CAUSE (Final cremation, disease or condition Vuscelu-(exebun) completely event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Peripheral burlal traumatic CERTIFICATION and Sequentially list conditione, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) 2 physician Chance cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST restasion the atter injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. shows any signed | 0 has be Dept. (DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hem certificate to the State **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Nome 5 sidence 8 - Other (Specify) 5 the 27. MANNER OF DEATN 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? this c is marked, 1 Natural
2 Accident 5 Pending м 1 YES 2 NO BY After Investigation 28s. PLACE OF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify) 3 Suicide 8 Could not be 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR: / hours after of item 28 is 4 Homicide 29a, CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, daeth occurred at the time, data and place, and due to the cause(a) and manner as stated.

| CERTIFYING PNYSICIAN: To the best of my knowledge, daeth occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL C within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29c. LICENSE NUMBER

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 24) (Type, Print) Buescher MM

SI. REGISTRANG SIGN URE

Physicis

Union

CERTIFICATE OF DEATH

95 34988 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATN 3. TIME OF DEATH YEAR 11/16/95 7;50 AM 8. BIRTHPLACE (State or Foreign N.C. 9c. COUNTY OF DEATN BALTO. CITY 10d. INSIDE CITY 1 # YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. **AMERICAN** 16b. KING OF BUSINESS/INDUSTRY BUILDER 20c. LOCATION — City or Town, State LANSDOWNE, MD. Approximats intervel Between Onset and Death 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO 28d, DESCRIBE NOW INJURY OCCURED

DHMN-16 Rev 1/89

Pages 1, 2, 3

permit.

After 1 death

DIRECTOR: hours after 28

BE

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2 MEDICAL EXAM

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29b. SIGNATURE AND TITLE OF CERTI

30. NAME AND ADDRESS OF PERSON FERNANDO 31. DATE FILED (Month, Day, 1847) NOV 2 1 1995

OR ATTENDING

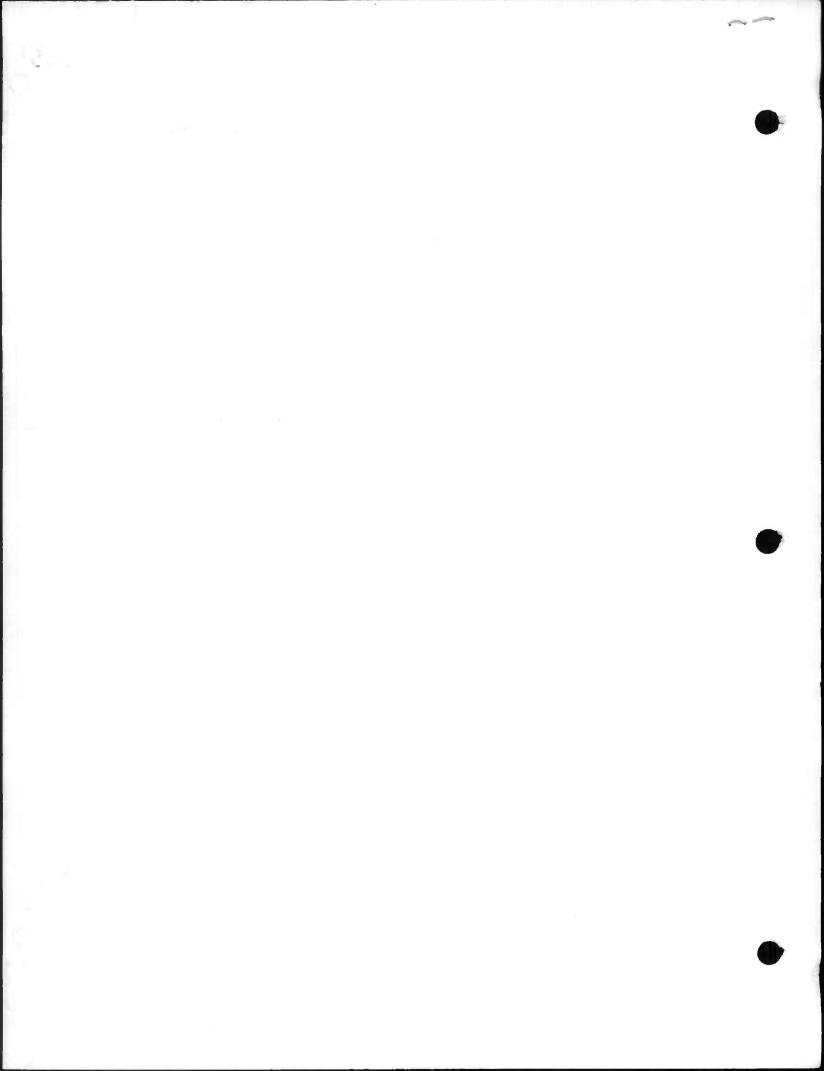
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95 34989 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Leat) 2. DATE OF DEATH 3. TIME OF DEATH 9°5 BOYD ALANDER 5:30 Pm 4 NOV. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leat birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 8 M 2 - F 218 18 3982 9/3/24 MD. 9a. FACILITY NAME (If not Institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MERCY HOSPICE BALTIMORE BALTO. CITY RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTO. CITY BALTIMORE MD. ## YES 2 | NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2725 WALBROOK AVE. USA 21216 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2# NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried If yes, specify Cuban, Maxican, Puarto Rican, stc.) 1 TYES 2 # NO Specify: BY 3 Widowed 4 Divorced AMERICAN COMPLETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe ollege (1-4 or 6 +) 12 SUPERVISOR MD. CUP CO. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JOHN BOYD PINNER notified at IDA BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 **ALONZA** 3410 woodbrook ave. BALTO. MD. 21217 BOYD 2 20a, METHOD OF DISPOSITION
1 # Burial 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must ARBUTUS PARK 11/18/95 ARBUTUS, examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 201 1300 EUTAW PL. BALTO. MD. 21217 23. PART I. Enter the diseases, Dr complications that caused the death. Dp not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause of each line. **Approximate** interval Betwe IMMEDIATE CAUSE (Final Onset end Death # disease or condition CANCER BASTRIC METASTATIC Inknown event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): if env. leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events other DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST 6 Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY ашу 1 TYES 2 NO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO INCERTAIN PHYSICIAN: S 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Rem **EXAMINER?** HOSPITAL: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Residence 6 Other (Specify) HOSPIGE ò 27. MANNER OF DEATH 26a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT marked, 1 Natural В Accident 3 Sulcide COMPLETED 8 Could not 4 Homicide detarmined 29a. CERTIFIER 1 CERTIFYINO PH TO THE HOSPITAL TO THE FUNERAL DE filed within 72 h

on		м	1 YES 2 ND						
be I	28a. PLACE OF INJURY — At hom building, atc. (Specify)	e, farm, street, facto	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
	N: To the best of my knowledge, dest On the besis of exemination and/or in				manner as stated.				
FIER	Unous		29c. LICENSE	NUMBER 0480	29d. DATE SIONED (Month, Day, Year) 11/14/95				
WHO C	DMPLETED CAUSE OF DEATH (ITEM	.5	BHUTO	MD Z	1206				
Jul	i d'avaleur bardell								
					DHMH-16 Rav				



Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

d within hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt. of Health and Mental Hygiene prior to burial, cremotal.	id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nous after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fat fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traum

1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF	EALTH AND DEATH	MENTAL	HYGIENE REG. NO.				
	Y BRAN	7			2. DATE MONTH		9 9	EAR 3. TIME OF	F DEATH	
4. SOCIAL SECURITY NUMBER 212-16-3622 9a. FACILITY NAME (If not institution, g	1 M 2 F	81 YRS. M	F UNDER 1 YEAR ONTHS DAYS Db. CITY, TOWN	HOURS MIN.	(Month	OF BIRTH o, Day, Year)		BIRTHPLACE (Sta Country) 3 ALT A OF DEATH		
PRESIDENCE OF DECEDENT										
10a. STATE 10b. CO	BALTO	10c. CITY,	Ba1	timore		10d. INS LIM 1 YE			E CITY S? 2 NO	
100. STREET AND NUMBER 531 STEVE	STEVENSON LANE			1. ZIP CODE	6	10g. CITIZEN OF WHAT COUNTRY?			TRY?	
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES			ENDENT OF HISPA ecity Cuban, Maxici 2 NO Specia	an, Puarto F					
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4 or 5 +)			ON ost of working	16b.	KIND OF BUSIN	IESS/INDUS	TRY		
unk		Cashier/	check	G	aint Fo	ood S	tore			
17. FATHER'S NAME (First, Middle, Last				18. MOTHER'S NA			rname)			
Edward	Waxter			Minni	-					
Edward Waxter 19a. INFORMANT'S NAME (Type/Print) Catherine Heavel 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City 934 (2C) West Warren St., She										
20a, METHOD OF DISPOSITION 1 Duriet 2 Cremation 3 4 Donation 6 Other (Specify)	Ramoval from State Cer	b. PLACE AND DATE OF metery, cremetory or othe	DISPOSITION (N r plece)	arne of	OATE	20c. LOCA	TION - City	or Town, State		
21. SIGNATURE OF FUNERAL SERVICE		Oodlawn C	22. NAME A	ND ADDRESS OF FA	CILITY			ore, Md		
· M. Kyll	- Sech.	h	1	an Seitz Roland A					211	
23. PART I. Enter the diseases, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										
Sequentially list conditions, if any, leading to immediate cause. Entar UNDERILYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. Sewile Jementic DUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant cond	tha undarlyin	PER			IN AUTOPSY DRMED? 24b. WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF DEATH? 1 \(\subseteq \text{ YES 2 } \subseteq \)		PRIOR TO ON OF CAUS			
25. WAS CASE REFERRED TO MEDICA			26. P	LACE OF DEATH (C/	neck only on	e)				
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Out	petient 3 DOA 4	THER: Nursing Hor	ne 5 🗆 Residence	6 🗆 Other	(Specify)				
27. MANNER OF DEATH	28s. DATE OF INJUSTY (Month, Day, War)	26b. TINE		JURY AT DRIC7	28d. DES	CRIBE HOW INJ	URY OCCUR	ED		
Natural 5 Pending Investigat	38e. PLACE OF WUUR		YES 2 NO	28f. LOCA	ATION (Street and	f Number of	Rural Route Numbe			
Homicide determine	Homicide determined building, etc. (Sectly)									
Check only 1 CENTINY INC.	HYSICIAN To the heat of my know							euse(s) and mann	er an stated	
296. SIGNATURE AND TITLE OF CONT	ATURE AND TITL OF CENTIFIES				29c, LICENSE NUMBER				, Year)	
MARIC LEAV										
31. DATE NOV 9 1 1995	32. REGISTRAR'S SIGN			- 4 4 4	00	71	- /			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death	THE FUNERAL DIRECTOR: After this	flied within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	RPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITA	TO THE FUNERA	be filed within 7	MPORTANT: I

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE	OF DEATH	REG. NO								
	1. DECEDENT'S NAME (First, Middle, Last)	2 1	2. DATE OF DEATH	AY YEA	3. TIME OF DEATH						
	MABEL E, BESAW		NOVEMBER.	14 1999	5 4:50 AM						
	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. 81 Co Sp	Mass. ringfield						
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
DIRECTOR	Mercy Hospital Center Balto.City,Md. none										
3EC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?										
2	Maryland none Balto.City,Md.										
AL	10e. STREET AND NUMBER	101. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?						
EB	600 Light St. Apt.# 735	2123	0	Unite	d States						
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 1 Never Merried 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO If YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yee, specify Cuben, Mexican, Puerto Rican, atc.) 14. RACE—Black, WI 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yee, specify Cuben, Mexican, Puerto Rican, atc.) 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yee, specify Yes or No—If yee, yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—If yee, specify Yes or No—										
	3 XX Widowed 6 Divorced										
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16e. KIND OF BUSINESS/INDUSTRY (Give kind of working most of working)										
LE	Elementary/Secondary (0-12) College (1-4 or 5+) 11-b Coron do Responder (0-12) College (1-4 or 5+) The secondary (0-12) Responder (0-12) Res										
ME	11th.Grade none Telephone Operator Bell Atlantic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										
CC	Thomas Hayes			Pomero	v						
BE		Street and Number or Rural			4						
2	Denise Metzger 8042 Kim	berly Rd.	Balto, M	d. 212	2.2						
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSIT			OCATION - City of							
	XX Burlel 2 Creptalton 3 Removal from State cemetery, crematory or other place) 4 Donetton 5 Other (Specify) Cedar Hill	Cemeterv1	1/16/95	A.A.Co	. Md.						
		AME AND ADDRESS OF F	CILITY	o.Md.							
-3	McCully Funeral Home, 130 E. Fort Ave										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the				Approximate						
	ahock, or heert failure. List only one cause on each line.			,	interval Between Onset and Death						
	disease or condition										
	DUE TO (OR AS A CONSEQUENCE OF):										
7	Sequentially list conditions, Due to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, If eny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
CAI	cause. Enter UNDERLYING										
E	CAUSE (Disease or injury that initiated events Due TO (OR AS A CONSEQUENCE OF):										
ER	resulting in dasth) LAST										
C	PART ii. Other significant conditions contributing to death but not resulting in the unc	erlying couse given in	Pert i. 24s. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS						
DICAL			PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE						
ш			T TES	2 32 NO	OF DEATH?						
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES A	O D UNCERTA	N D		1 YES 2 NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check of										
SIC	EXAMINER? 1 YES 2 2000 1 1 2 1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2	: ng Home 5 🗆 Residence	8 Other (Specify)								
H	27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW	INJURY OCCURE	D						
	1 ★ Netural 5 Pending (Month, Day, Year) INJURY	WORK? 1 YES 2 NO									
D BY	3 Suicide 28e. PLACE OF INJURY — At home, farm, street, facto	ry, office	281. LOCATION (Street		ural Route Number,						
TEL	4 Homicide determined building, stc. (Specify)		City or Town, State	,							
E	29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the tire	ne, date end place, and du	e to the cause(e) end m	enner ee stated.							
COMPLETE	(Check only one) 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my or				use(e) end menner ee stated.						
	29b. SIGNATURE AND TITLE OF CERTIFIER	29c, LICENSE NU	IMRER	29d DATE SIC	GNEO (Month, Day, Year)						
B	Do	P09			mber 14, 1995						
5	ANO AOORESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)	1.01		14000							
	JAMES PARK 301 ST. PAUL PLACE	BALTUM	IORE, MD	21202							
		, 0.1-1411									
	31. DATE PHOLYME DIX 1995										

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	ITMENT OF HICATE OF	IEALTH AND M DEATH	IENTAL HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)			DI Ni	5	2. DATE OF DEATH	Y YEAR	3. TIME OF DEATN			
- i	JOSEPH 4. SOCIAL SECURITY NUMBER	I a seri		DLHI	R	November	14 1995	2:35 Pm			
63	216-54-5061	5. SEX 6. AGE	MONTHS DAYS HOURS MIN (Month, Day, Year)					950 8. BIRTHPLACE (State or Foreign Country)			
		JTY NAME (If not inatifution, give street and number)			OR LOCATION OF DEA	July 15,		95 Maryland			
H	Good Samaritan Hospital				altimor						
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			Y, TOWN OR LOCAL			n/:				
DIRECTOR					ddle Ri	10d. INSIDE CITY LIMITS?					
N.	10e. STREET AND NUMBER			ZIP CODE	1 YES 2 XNO 10g. CITIZEN OF WHAT COUNTRY?						
FUNERAL	511 Nollmeye			2	USA	mai coomini					
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Yes	or No 14, RAI	CE American Indian, ck, While, alc.			
BY	1 Never Married 2 Married 3 Widowed 4 Dovorced	IF YES, GIVE WAR OR D			2 X NO Specify:	Poerto Ricen, etc.)		icity:			
	15. DECEDENT'S EDUC	CATION	18a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUS	INFSS/INDUSTRY	White			
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of the Do NOT us	work done during mo se retired.)	st of working						
COMPLETED	11th		Dr	iver			nstar				
	17. FATHER'S NAME (First, Middle, Last) Bernard Bl	air			18. MOTNER'S NAM	E (First, Middle, Malden	Sumame) MAE	WITTHAUER			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		oute Number, City or Town					
٩	Bernardine R	ob1				Baltimr		21224			
	20a, METHOD OF DISPOSITION 1 Burlal 2 Commation 3 Rame		D. PLACE AND DATE of		me of	DATE 20c. LO	CATION — City or 1	Town, State			
	4 Donation 5 Other (Specify)	M	<u>letroCre</u>	ematory	Inc. 11	/16/95 B	altimo	re Md			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	11		O 1 1 T F11	um neral Ho	mo of	Facer			
15	C. May	1 Onnel	ly	300	Maco Am	0 Ra1+i	moro M				
	23. PART i. Enter the diseases, or shock, or heart failure	complications that caused List only one cause on a	d the death oo reach Ina.	not entar tha mo	da of dying, such	as cardiac or reapi	ratory arrest,	Approximata interval Batween			
	iMMEDIATE CAUSE (Final disease or condition		h	1 0	20	١		Onset and Death			
	reauiting in death)	DUE TO (OR AS /	A CONSEQUENCE OF	FI:	Bloco			4 days			
Z	Sequentially list conditions, a Bleeding Metastatic Molanoma in the Brigh ~ 6 months										
ATIC	or control of the con										
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	ŋ:							
CERTIFICATION	resulting in death) LAST	d									
	PART II. Other significant conditions	a contributing to death b	out not resulting	n the underlying	cause given in P	art i. 24a. WAS AN	ALITOPSV 24	b. WERE AUTOPSY FINDINGS			
ICAL					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
빌						1 TYES 2	Z NO	OF DEATH? 1 ☐ YES 2 NO			
ż	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YE	S 🗆 NO 🗵	UNCERTAIN						
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEAT	N (Check anly one) OTHER:							
S ↓	1 VES 2 NO 27. MANNER OF DEATN	1 Sinpstient 2 ER/Outp		4 - Nursing Nom	5 Residence 8						
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIMI INJ	URY WO	JRY AT RK? ES 2 NO	28d. DESCRIBE NOW IN	JURY OCCURED				
B D	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, ferm, a			281. LOCATION (Street a	nd Number or Rural	Route Number,			
ETED	4 Homicide determined	building, atc. (Spec	спу)	At home, ferm, atreet, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)							
릴	29e. CERTIFIER (Check only one)	CIAN: To the best of my know	ledga, death occurre	d at the lime, date	end place, and due to	the cause(a) and man	ner ea stated.				
COMPL	2 MEDICAL EXAMINER	R: On the basis of examination	n and/or investigatio	n, in my opinion, d	eath occured at the ti	me, data and place, and	f dua to the cause	(a) and menner as stated.			
BE	296. SIGNATURE AND TITLE OF CERTIFIER		11		29c. LICENSE NUMB			D (Month, Day, Year)			
၉	30. NAME AND ADDRESS OF PERSON WING	COMPLETED CAUSE OF DE	ATN (ITEM 27) (5	Print)	P093	11	Nov	16,95			
	Michel Torbe	(-1)	och Rai	ren Bl	ud, B	altimore	2 71 1	21239			
	31. DATE PILED (Month, Day, Year)	REGISTRAS'S SIGN									

N. S.

31. OATE FILED (Month, Day, Year)
NOV & 1 1995

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

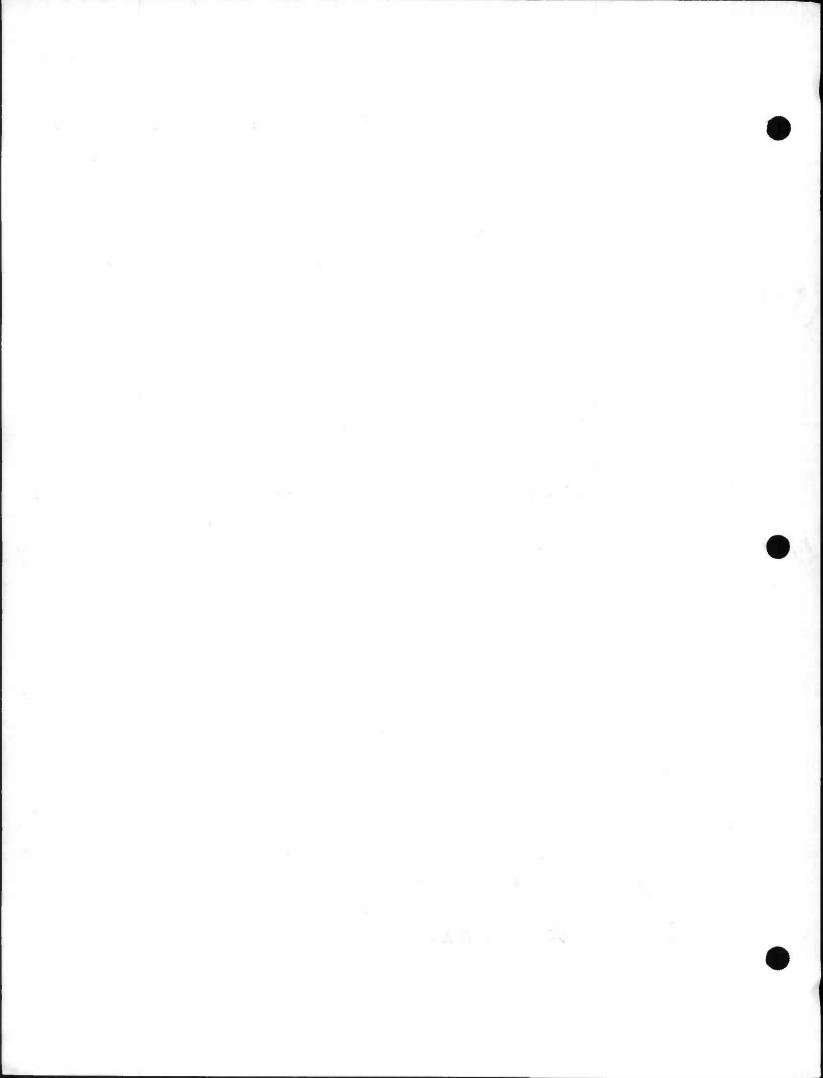
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

					95	34993			
	1 - STATE OF MARYLAND / DE CERT	PARTMENT OF		MENTAL HYGIEN REG. NO.	_				
- 3	1. DECEOENT'S NAME (First, Middle, Last)			2. DATE OF OEATH	V VEAR	3. TIME OF DEATH			
	HERBERT E. BREWSTER			NOV. 15	1995	0728 Am			
- 8	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birth			7. DATE OF BIRTH (Month, Day Year) Dec 3, 1	6. BIF	TTNPLACE (State or Foreign			
	218-52-4730 SCRM 2 F 46 YI	RS. MONTHS DA	WN OR LOCATION OF OR	Tenn.					
LOH	FALLSTON GENERAL HOSPITAL	FALL		AIN	HARFO				
ក្ខ		c. CITY, TOWH OR LO	CATION			10d. INSIDE CITY			
DIRECTOR	Md. Baltimore		Baltim	ore		LIMITS?			
FUNERAL	1629 B Elrino Street		10f. ZIP CODE	21224		F WHAT COUNTRY?			
Ž	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	13, WAS	DECENDENT OF NISPAN	IIC ORIGIN? (Specify Yes	or No.— 14. R	ACE — American Indian,			
BY FI	1 Never Merried 2 Merried FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES	If yes	yes 2 NO Specify	n, Puerto Rican, etc.)	Bi	lack, White, etc.			
	15. OECEOENT'S EDUCATION 16a. DECEDE	ENT'S USUAL OCCU	PATION	165 KIND OF BUIL	I SINESS/INDUSTRY	White			
COMPLETED	(Specify only highest grade completed) (Give kir	nd of work done durin NOT use retired.)	g most of working						
MP	12th	Carper	ter	Uni	on Loc	al 1110			
00	17. FATNER'S NAME (First, Middle, Last)		18. MOTNER'S NA	ME (First, Middle, Maiden	Sumame)				
ш	Bruce Brewster		Eth	el Cook					
TO B			et and Number or Rural F			Md. 21237			
	20e. METNOO OF DISPOSITION 1 Deuriel 2 Cremation 3 Removal from State cemetery, cremator	DATE OF DISPOSITIO	N (Name of	OATE 20c. LO	CATION — City or	Town, State			
			etery 11		<u>altimo</u>	re MD.			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	, Cor	nelly Fu	neral Ho					
	23. PART I. Enter the diseases, or complications that caused the death	300	Mace Av	e Balti	more M	D. 21221 Approximata			
	shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Able	minel I	Diune	.C	interval Between Oneat and Death			
7	DUE TO (OR AS A CONSEQUEN	ICE OF):		/					
ERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	ICE OF):							
TFIC	CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUEN	ICE OF):							
CERI	resulting in death) LAST								
AL	PART II. Other significent conditions contributing to deeth but not resul	iting in the under	iying cauae given in	Part i. 24a. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
PHYSICIAN: MEDICAL				1 YES :	⊇ □ NO	COMPLETION OF CAUSE OF DEATN?			
ME				_ ' `		1 YES 2 NO			
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	YES NO	UNCERTAIL	N 🗆		/ \			
¥.		F OEATN (Check only	ohe)						
SIC	EXAMINER? 1 X XES 2 ☐ NO HOSPITAL: 1 ☐ Inpatient X XER/Outpatient 3 ☐ □	OTHER:	Nome 5 - Residence	6 Other (Specify)					
Ť	27. MANNER OF OEATN 28s. DATE OF HALLYTY 26	b. TIME OF 28d	: INJURY AT WORK?	20d. OESCRIBE NOW	INJURY OCCURED	Λ.			
ВУБ	1 Natural 5 Pending Accident Investigation		☐ YES 2 NO	Inver 1	Javo	accident			
	The state of the s	ferm, street, fectory,	office	28f. LOCATION (Street	and Number or Rui	ral Route Number,			
TE	4 Nomicide determined	EET		US ATE	1 and	ownelly A.			
COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death of the best of the best o								
	299 SINGSATURE AND TITLE OF CERTIFIER	myanon, in my opini	29c, LICENSE NUI						
TO BE	(an or (or he M)		O.C.M		NOV	NEO (Month, Day, Year) • 17, 1995			
-		enn Str	eet, Bal	timore,	Maryla	nd 21201			
	31. OATE FILED (Month, Day, Year) NOV 2 1 1995 A Walter hardely								

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that the deal	d by the atte	and Mental	my Injury, o
ires that the deal	signed by the atte	leafth and Mental	ws any injury, o
requires that the deal	een signed by the atte	of Health and Mental	shows any injury, o
law requires that the deal	as been signed by the atte	Jept. of Health and Mental	23 shows any injury, o
: The law requires that the deal	ate has been signed by the atte	tate Dept. of Health and Mental	tem 23 shows any Injury, o
CIAN: The law requires that the deaf	artificate has been signed by the atte	the State Dept. of Health and Mental	or item 23 shows any injury, o
HYSICIAN: The law requires that the deal	is certificate has been signed by the atte	with the State Dept. of Health and Mental	ted, or item 23 shows any injury, o
IG PHYSICIAN: The law requires that the deal	ter this certificate has been signed by the atte	ath with the State Dept. of Health and Mental	narked, or item 23 shows any injury, o
NDING PHYSICIAN: The law requires that the deal	3: After this certificate has been signed by the atte	ir death with the State Dept. of Health and Mental	is marked, or item 23 shows any injury, o
ATTENDING PHYSICIAN: The law requires that the deal	CTDR: After this certificate has been signed by the atte	s after death with the State Dept. of Health and Mental	28 is marked, or item 23 shows any injury, o
DR ATTENDING PHYSICIAN: The law requires that the deal	DIRECTOR: After this certificate has been signed by the atte	hours after death with the State Dept. of Health and Mental	item 28 is marked, or item 23 shows any injury, o
ITAL DR ATTENDING PHYSICIAN: The law requires that the deal	RAL DIRECTOR: After this certificate has been signed by the atte	72 hours after death with the State Dept. of Health and Mental	: It item 28 is marked, or item 23 shows any injury, o
IOSPITAL DR ATTENDING PHYSICIAN: The law requires that the deaf	UNERAL DIRECTOR: After this certificate has been signed by the atte	vithin 72 hours after death with the State Dept. of Health and Mental	ANT: It item 28 is marked, or item 23 shows any injury, o
HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the deat	HE FUNERAL DIRECTOR: After this certificate has been signed by the atte	led within 72 hours after death with the State Dept. of Health and Mental	ORTANT: It item 28 is marked, or item 23 shows any injury, o
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND / Ce	DEPAR RTIF	TMENT ICATE	OF H	EALTH DEAT	AND I	MENTA	L HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle,	Gladys	Margaret	Baı	rett				MONT	of DEATH DA	4 19	95 EAR	5:30 p. M	
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. lesi	t birthday)	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			8. BIRTHPI Country)	LACE (State or Foreign	
	242-42-0686	1 □ M 2 XXF	9	3 YRS.				9-12-1902				h Carolina		
~	9a. FACILITY NAME (if not institution, give street and number)				9b. CITY,			ON OF DE	EATH			INTY OF DEA		
6	16305 Dahl Roa				Laurel Prince Georg					eorge				
DIRECTOR		OUNTY		10c. CIT	Do. CITY, TOWN OR LOCATION 10d. INSIDE (LIMITS?						IOd. INSIDE CITY			
	Maryland H	Prince Geor	ge	L							YES 2 XXNO			
3AL	10e. STREET AND NUMBER						ZIP CODE				10g. CIT		AT COUNTRY?	
FUNERAL	16305 Dahl Roa						2070					US		
	11. MARITAL STATUS 1 Never Married 2 Merried	FORCES?	TEVER IN U.S. ARI		H	yea, spe	city Cuba	n, Maxica	in, Puerto	N? (Specify Yea Rican, etc.)	or No—		– American Indian, Whita, atc.	
ВУ	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE	MAR OR DATES		1	YES	2 📉 NO	Specify	y:			Specify Whi	te	
COMPLETED	15. DECEDENT'S (Specify only highest	S EDUCATION	18a. DE	CEDENT'S	USUAL OCI	CUPATIO	N st of workin	101	168	b. KIND OF BUS	INESS/IN	DUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5	+) life.	Do NOT u	se retired.)									
MP	1.2 17. FATHER'S NAME (First, Middle, La	2	S	ales	Agen	t						uranc	e	
	Henry Alexande	*								Middle, Maiden Hillia	,			
BE	19a. INFORMANT'S NAME (Type/Print			. MAILING	ADDRESS	(Street a				nber, City or Town		n Code)		
2	Brenda B. Schi	illing			305 D					el, Ma			0707	
	20a. METHOD OF DISPOSITION		20b. PLACE	ND DATE	OF DISPOSIT	TION /Na	me of		DAT			Y — City or Town, State		
	XXBuriat 2 Cremation 3 4 Donation 5 Other (Specify,	Page interest	Fores	t Hi						7 – 95 F	armv	ille,	NC	
	A SIGNATURE OF FUNERAL SERVI	CE LIGHTSEE	1)				Fun			ne, Inc				
	· / Colal	DUDAG	ley							Road		rel,	MD 20707	
	23. PART I. Enter the diseases ahock, or heart this	or complication in	at caused the de	ath. Do	not enter t	he mo	de of dyi	ng, suc	h as car	diac or reapi	retory ar	reat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final			\									Onset and Deeth	
ı	disease or condition resulting in death) Arteriosclerotic cardiovascular disease													
_	DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
CA	CAUSE (Disease or Injury C.													
	that initiated events reaulting in deeth) LAST	DUE TO	OR AS A CONSEC	DUENCE C	F):									
S		d				-							1	
AL	PART II. Other algnificant con	ditions contributing to	death but not n	esuiting	in the und	lerlying	g cause g	given in	Part i.	24a. WAS AN PERFOR			VERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL										1 TYES 2	X NO		COMPLETION OF CAUSE OF DEATH?	
M	DID TODA GGO LIGE GG	0 1 1 T 1 T 1 T 0 T 0 T 1	1105 05 05 1				1 1010						YES 2 NO	
AN	DID TOBACCO USE CO				TH (Check o		UNC	ERTAI	N L					
Sici	EXAMINER?	HOSPITAL:	☐ ER/Outpatient 3		OTHER	:	. e (\$\forall res.	ald. a.a.	a [] (M)	(6				
H	27. MANNER OF DEATH	28a. DATE O	F INJURY	28b. TIR		28c. INJ	URY AT	IBIGETICAL		SCRIBE HOW I	NJURY OC	CURED		
ВУ Р	1 X Natural 5 Pending 2 Accident Investig	3	Day, Year)	IN	JURY		RK? res 2] NO						
	3 Suicida 6 Could n	28e. PLACE of building	OF INJURY — At ho	me, term,	street, facto	ry, offic	0			CATION (Street of or Town, State)		or Rural Ro	ute Number,	
COMPLETED	4 Homicide determin	ned												
APL	one) em	PHYSICIAN: To the best of												
Ö	2 X MEDICAL EX	(AMINER: On the basis of	examination and/or i	investigati	on, in my op	inion, d	eath occur	red at the	time, date	a and place, an	d due to t	ha cause(a)	and manner as stated.	
BE	296. SIGNATURE AND TITLE OF CEI	TIEBER ()	6	711.	-			D212					Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSO	ON WHO COMPLETED CAL	ISTE OF DEATH ATE	M 27) /Turn	Print)			D212	200		INC	vembe	r 15, 1995	
	Augusto P. Rodi	/		- / () -		.,	Camp	Spr	ings	s, MD 2	0748			
	31. DATE FILED (Month, Day, Year) NOV 2 1 1995		AR'S SENATURE											
	MO & T 1322	July amount	-											
													DHMH. 18 Ray 1/8	



pital or attending physician. ed for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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10	10	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	M
Service Services	-	-	-

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIEN	E
		CI	ERTIFICATE	0	F DEAT	TH		REG NO	

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	Roy	7	Sarr	000	2. DATE OF DEATH MONTH D		S. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 242-82-2252 90. FACILITY NAME (If not institution, give s	1 🛛 M 2 🗆 F	(In yrs. last birthday)	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) November 15	1951	BIRTHPLACE (State or Foreign Country) Monroe, N.C.		
DIRECTOR	13537 Aston Manor Way			Silver		AIH	Montgo			
	MD Montgo		1.7	er Spring	ION			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	13537 Aston Manor Way			20	2IP CODE 1904		United	States		
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR C	2 NO	13. WAS DECI If yes, spe 1 — YES	city Cuben, Mexice	IIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	s or No 14.	RACE — American Indian, Black, While, etc. Specify: Black		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT use Security		N It of working	16b. KIND OF BU	ity Serv			
BE COM	17. FATHER'S NAME (First, Middle, Last) Charles Henry Barron				16. MOTHER'S NAI	ME (First, Middle, Maiden Robinson	Surname)			
10	19a. INFORMANT'S NAME (Type/Print) Avis L. Barron		3504 Ed	ADDRESS (Street ar wards Stre	et Spring	doute <i>Number, City or Tow</i> Idale, MD 207	n, State, Zip Cod 74	io)		
	20e. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	car	p.PLACEANDDATEO metery, cramatory or oti altimore Wa	shington C 22. NAME AN Fleck F	rematory pappress of Fac uneral Hom	11/10 Laur	cation — chy el, Mary , Maryla	land		
CATION	iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	d the deeth. Do not not line. A CONSEQUENCE OF):		cles		Approximata Interval Batwean Onset and Death		
CERTIFICATION	CAUSE (Disease or injury thet initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):						
MEDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO									
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE O	20. PLACE OF DEAT		UNCERTAIN	10				
BY PHYS	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Apeldent Investigation	1 Inpatient 2 ER/Out	Petient 3 DOA	4 Nursing Home	IRY AT	28d. DESCRIBE HOW INJURY OCCURED				
1 1	3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY building, etc. (Spe	/ — At home, farm, st	reet, fectory, office	1 sectory, office 261. LOCATION (Street and Number or Paral Route Number, Way 13531 A ASTON					
COMPLETED		ICIAN: To the best of my know ER: On the basis of exemination						me.		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	and	De v	9	29c. LICENSE NUM	BER	29d. DATE SIG	GNED (Month, Day, Year) Up. 9-95		
	30. NAME AND ADDRESS OF PERSON WH	D COMPLETED CAUSE OF DE	20 - 03	Print)	wis	PRETTO	N F	lue.		
	NOV 2 1 1995	Sz. REGISTRAR'S SIGN	ALL							



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ysician and completely filled in by the prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or rem	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medic
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH VEAD Elnora M. Brock Nov. 18, 1995 8:15 PM М 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 6. AGE (In vrs. last birthday IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 X F 90 577-18-7702 YRS March 30, 1905 Washington, D.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Mariner Nursing Home Laurel Prince George RESIDENCE OF DECEDENT 10d. INSIDE CITY 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Prince George Maryland Laurel 1 YES 2 NO 10e STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15813 Bond Mill Road 20707 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 15 MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES GIVE WAS OR DATES 1 TES 2 X NO Specify ΒY 3 K Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 186. KIND OF BUSINESS/INDUSTRY /Sn Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk U.S. Government none 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leon Milstead Lizzie Shaw BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Juanita B. Dean 15813 Bond Mill Road, Laurel, Maryland 20707 20s. METHOD OF DISPOSITION
1 X Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Arlington National Cemetery 4 Donation 5 Other (Specify) Arlington, Virginia 21. SIGNATURE OF FUNERAL SERVICEYLICENSEE 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 QUADO 23. PART /. Enter the diseases, or comp the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heart fallure. List only one Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) chronic obstructive lung disease years OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause Enter LINDERI VING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 X NO OF DEATH? 1 YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 Y NO 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 [X] Natural 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, larm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29s. CERTIFIER

**Chack only

1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIED 29d. DATE SIGNED (Month) Day, Year) 29c. LICENSE NUMBER BE DZ4997 18/95 Miles 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8317 198) CASAS CHETLRY LANE m) LAUROR 20707 NUV 2 1 1995 32 AREGISTRAR'S BNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIFI	CATE OF	DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DA	W.	YEAR	3. TIME OF DEATH	
	Pensacola				Byrd		A A A A A CALODO		195	12:30 AM	
	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8, BIRTH	PLACE (State or Foreign	
	217-22-6352	1 🗆 M 2 📝 F	84	YRS.	MONTHS DAYS	HOURS MIN.	June 4 191	11	Country	h Carolina	
	9e. FACILITY NAME (If not institution, give st	reet and number)	U-T		9b. CITY, TOWN	OR LOCATION OF DE		9c, COUN			
۳ ا			1					N/			
Union Memorial Hospital RESIDENCE OF DECEDENT 100. STATE 100. COUNTY MARYLAND N/A BALTIMORE CITY											
Ĕ I	10a. STATE 10b. COUNTY			10c. CITY,	TOWN OR LOCA	TION				10d. INSIDE CITY	
声	MARYLAND N/	Δ		10	BALTIMO	DE CITY				LIMITS?	
	10e. STREET AND NUMBER					I. ZIP CODE		10g, CITIZ	ZEN OF W	THAT COUNTRY?	
FUNERAL	2416 Diadmont Aug					0101/					
z I	3416 Piedmont Ave	12. WAS DECEDENT E	EVED IN H C. ADA	IED.	12 MMC DE	21216	IIC ORIGIN? (Specify Yes		.S.A		
	1 Never Merried 2 Merried	FORCES? 1	YES 2 X N	0	If yes, sp	ecify Cuban, Maxica	n, Puerto Rican, etc.)	01 140		— American Indian, , White, atc.	
B	3 X X Widowed 4 □ Divorced	IF YES, GIVE WAF	OR DATES		1 TYES	2 X NO Specify	<i>y</i> :		Spech	BLACK	
	15. DECEDENT'S EDUC	ATION	18a, DEC	EDENT'S U	SUAL OCCUPATI	ON	16b. KIND OF BUS	INESS/INDI	ISTRY	DEAGK	
ETEO	(Specify only highest grade	completed)	(Giv	e kind of wo	ork done during me retired.)	ost of working	los. Killo di Bos	MAE 33/MO	OSINI	13.1	
7	Elementery/Secondary (0-12) 12th grade	College (1-4 or 5 +)	DAV	CADI	E PROVI	DED	SELF	EMDL	OVED		
COMPL	17. FATHER'S NAME (First, Middle, Last)		LUAT	CAR	PROVI		ME (First, Middle, Maiden	-	UTEU		
								Surname)			
BE	RICHARD A. BROWN 199. INFORMANT'S NAME (Type/Print)		404		DDDF00 (O)		UTCHINSON				
임	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CD					Route Number, City or Town			1 01015	
	NATHANIEL H BYRD 200. METHOD OF DISPOSITION	SR.					Baltimore				
- 1	1 X Buriel 2 ☐ Cremetion 3 ☐ Remo	oval trom Stata	cemetery cren	atory or oth	F DISPOSITION (N er place)			CATION — C			
-	4 Donellon 5 Other (Specify)	where)	LMARYL	AND I			LL11/24 BAL	TIMO	RE M	ARYLAND	
- 1	In some of one has service to	7)/	0			ND ADDRESS OF FA	ROWN COMMUN	VTTL	F/H		
	1 Hani	(T. (lose			W. NORTH		1111	7 11		
	23. PART I. Enter the diseases, or o			th. Do no				ratory arm	est,	Approximate	
	shock, or heart fellurs.	Liet only one ceuse	on each ilne.							Interval Between Onset and Death	
	IMMEDIATE CAUSE (Finel disease or condition	Day 15	a. T. ci	41	Li prati	eial 9	a Bay of the				
- 1	resulting in death)	DUE TO (O	R AS A CONSEO	UENCE OF	- Contract	a de	mar eurn			lday	
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Ĕ	CAUSE (Disesse or injury that initiated events	DUE TO (O	R AS A CONSEO	JENCE OF)	:						
	resulting in death) LAST										
5											
SA	PART II. Other significant condition	-							24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
	Non ansulu	a depe	udant	70	1 oracly	milli	tus 1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?	
ME										1 YES 2 NO	
	DID TOBACCO USE CONTI	RIBUTE TO CAU	SE OF DEAT	H YES	ON D	UNCERTAIL	N D				
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEATH	(Check only one)						
i n	1 (VYYES 2 NO	HOSPITAL:	R/Outpetlant 3		OTHER:	na 5 🗔 Residence	8 Other (Specify)				
РНҮ	27. MANNER OF DEATH	28e. DATE OF IN		28b. TIME	OF 28c, IN	JURY AT	28d. DESCRIBE HOW I	NJURY OCC	URED		
	1 Natural 5 Pending	(Month, Day,	Year)	INJU		YES 2 NO					
B	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	INJURY — A1 hor	ne, 1erm, st	reet, factory, offic	De .	281. LOCATION (Street a	nd Number	or Rural F	Route Number,	
	4 Homicide datermined	building, at	c. (Specify)				City or Town, State)				
	29e. CERTIFIER	NAME TO ALL DESIGNATION	13U 5 5								
COMPL	anal						to the cause(s) and men				
3				veayation	, ar my opinion,	water occured at the	time, date and place, an	o out 10 Th	- Cause(e	y enter menner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	D.	m. 7	LIA		29c. LICENSE NUI		29d. DATE	SIGNED	(Month, Day, Year)	
	(Selun. (Suraing Begun), MD AT 2438946 11/19/95										
o I	German () octor		1								
2	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE	OF DEATH (ITEM	27) (Type,	Print) MEDI	CINE, UM	110N MEMO	RIAL	1+0	SPITAL	
2	30. NAME AND ADDRESS OF PERSON WHITE AND ADDRESS OF PERSON WHITE ADDRESS OF PE	COMPLETED CAUSE	OF DEATH (ITEM	BAL	Print) MEDI. TIMOX	CINE, UN	110N MEMO - 212	RIAL	1+0	SPITAL	
0	30. NAME AND ADDRESS OF PERSON WHO DE SURALYA STATEMENT OF THE SURALYA	O COMPLETED CAUSE EAUM ARKWAY 320 REGISTRAR		BAL	Print) MEDI TIMOX	CINE, UN	110N MEMO 0 - 212	RIAL 18	He	SPITAL	

REG. NO

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

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1 DECEDENT'S NAME (First Middle Last) 2. DATE OF OEATH 3 TIME OF OFATH 7995 BAREHAM NOVEMBER 18 JAMES AM RUSSELL 9:25 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 6. AGE (In vrs. last birthday) S. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. Month, Day, Year) 6/27/1917 1 🛛 M 2 🗌 F 78 219-18-8428 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF OEATH GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE DIRECTOR RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Cockeysville Baltimore Maryland 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE 21030 U.S.A. 204 Duke of York Lane bunal-transit fter death. Page 6 may be retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, Whita, atc. Specify: White 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 X Married 1 YES 2 X NO Specify: Specify: BY 3 Widowed 4 Divorced as the ETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY use a (Spe funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL Baltimore County Government Public Works Supervisor 7th n/a once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at James Bareham Mary Ann Freeland Henry BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 204 Duke of York Lane Cockeysville, MD 21030 Bertha Lillie Bareham pe 20s. METHOD OF DISPOSITION
1- Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Steta must Poplar Grove Cemetery Phoenix, Maryland 4 Donetion 5 Other (Specify) 21, SIGNATURE OF FUNCHAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Lemmon Funeral Home of Dulaney Valley, Inc. examiner bove II M. Lemmon Timonium, Maryland 21093 10 W. Padonia Road filled in by the fillion, or removal. medical 23. PART I. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximata interval Between shock, or heart failure. List only one cause on each line. Onset and Death IMMEDIATE CAUSE (Final the cremation, disease or condition resulting in death) ROCHAY Znus completely 1 event. DUE TO (OR AS A CONSEQUENCE OF) to burial, traumatic CERTIFICATION and Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING physician prior CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 6 the atter Mental inluy, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MEDICAL 24e. WAS AN AUTOPSY AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? and t any signed l 1 YES 2 THO shows a 1 YES 2 NO been f. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO. UNCERTAIN I PHYSICIAN: has be Dept. 23 26. PLACE OF DEATN (Check only 25. WAS CASE REFERRED TO MEDICAL certificate h item EXAMINER? HOSPITAL:
1 Inpattent 2 ER/Outpatient 3 DOA OTHER:
4 | Nursing Name 5 | Residence 6 | Other (Specify) 6 the 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED this c marked, 1 Natural
Accident 5 Pending Investigation 1 YES 2 NO BY After 26s. PLACE OF INJURY — At home, larm, etreet, lactory, office building, etc. (Specify) 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 69 8 Could not be COMPLETED DIRECTOR: hours after 500 4 Homicide item 29a. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(a) and manner as stated. FUNERAL F within 72 h = F _ MEDICAL EXAMINER: On the basis of axemination and/or investigation, in my opinion, death occured at tha time, data and place, and due to the ceuse(a) and manner as atteted. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29d. DATE StGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 130921 2 WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 6569 N. Chw 695+ 232. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

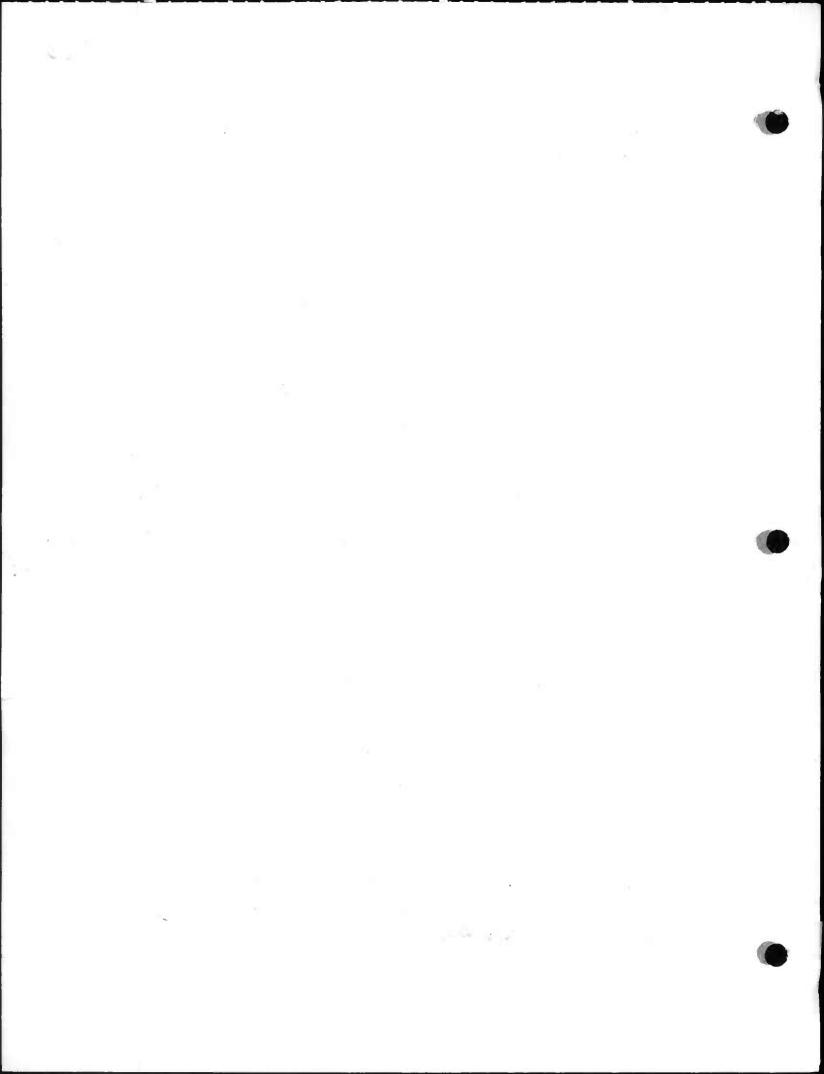
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First	, Middle, Last)									2. DATE OF DEATH		WE 4 =	3. TIME OF DEATH
Thelma		W.	Bak	er						November		995	3:10pm
4. SOCIAL SECURITY NUME		5. SEX	6. AGE (I	n yrs. lest	birthday)		DER 1 YEAR			7. DATE OF BIRTN (Month, Day, Year)		8. BIRTI	NPLACE (State or Foreign
220-46-48	$220-46-4827$ 1 \square M 2 \nearrow F 96 YRS. MONTHS DAYS HOURS 1						MIN.			MA F	RYLAND		
9e. FACILITY NAME (If not institution, give street and number)							TY, TOWN	N OR LOCATI	ON OF DE	EATN	9c. COU	NTY OF D	DEATN
BROADMEA						CO	CKE	YSVI	LLE		BA	LTIN	MORE
10e. STATE	10b. COUNTY	,	_		10c. CIT	Y, TOW	N OR LOC	CATION					10d. INSIDE CITY
MARYLAND	BALT	IMORE			COC	CKE	YSV	ILLE					LIMITS?
10e. STREET AND NUMBER							1	10f. ZIP COD	E .		10g. CIT	IZEN OF V	WHAT COUNTRY?
13801 YOR	K RD.							2103	30			S.A.	
11. MARITAL STATUS													
1 Never Merried 2 Married FORCES? 1 YES 2 NO It yes, specify Cuben, Mexicen, Puerto Rican, etc.) Black, White, etc.										k, White, etc.			
3 Widowed 4 Divo	rced								фоон	,		Spoc	WHITE
15. DEC (Specify only	EDENT'S EOU	CATION completed)		(Gh	ve kind of v	work do	L OCCUPAT	TION most of working	10	16b. KINO OF BUS	SINESS/IN	DUSTRY	
Elementary/Secondary (0		College (1-4 or 5	+)	life.	Do NOT us	se retire	id.)		•				
12				HO	USEV	VIF	E			НОМЕМА	KER		
17. FATNER'S NAME (First, M	.,,	_								ME (First, Middle, Maiden	Sumeme)		
TIMBROOK		E						BEU	JLAF	H FORD			
19e. INFORMANT'S NAME (7										Route Number, City or Town			
ROBERT W.	BAKE	R			$12 \mathrm{C}$	DLD	BO:	XWOOI) LA	NE LUTHE	RVI	LLE,	MD. 21093
20e. METNOO OF DISPOSIT Burial 2 Cremetic Donetion 5 Other	n 3 🗆 Reme	oval from State			ND DATE O		POSITION	Name of EMETI	ERV		CATION -		E, MD.
21. SIGNATURE OF FUNERA		ENSEE	101		2 1 1			AND ADDRE			KLD	v T 111	JE / HD •
► Wille	an R	· Pares	111							TENKINS & RD. BALT		-	
IMMEDIATE CAUSE (Fir disease or condition reculting in death) Sequantiely list condit if any, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or inju- thet initieted events reautting in deeth) LAS	dona, diate NG	b	(OR AS A	CONSEC	UENCE OF	F):	E						Interval Batween gheet and Death
		d,											
PART II. Other eignifice	T1-	INFA	RC	T	J	E	ME	EN	TIF	PERFOR	MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 100
25. WAS CASE REFERRED TO				_			ack only on		-1/1/411				
EXAMINER?		HOSPITAL:				ОТН	IFA:		sidence	8 Other (Specify)			
27. MANNER OF OEATH		28e. DATE OF	INJURY		28b. TIM	E OF	28c. II	NJURY AT	_ruerics	28d. OEŞCRIBE NOW II	NJURY OC	CURED	
	Pending Investigation	(Month, D	lay, Year)		INJ	IURY M		VORK?	NO				
3 Suicide 8	Could not be	28e. PLACE O building.	etc. (Special	— At hon	ne, ferm, a	atreat, 1	factory, off	fice		281. LOCATION (Street e City or Town, State)	nd Number	or Rural F	Route Number,
AA AFFERSE													
(Check only										to the cause(e) end men time, data end pieca, an) and menner se stated.
299, SIGNATURE AND TITLE BALLA 30, NAME AND ADDRESS OF BARBAR	OF CERTIFIER	arri	rll	- , ,	m		380		38				(Month, Dely, Year) 16/95 XSVILLE
31.NOV2/11199	5° Jul	Neces To	ह चान	TARE									1



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM BOUC!	HER III	2. DATE OF DEATH MONTH 11 - 1		3. TIME OF DEATH								
	216-14-8597	1 X M2□F 76	in yrs. lest birthday) YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) 3-18-1	BIRTHPLACE (State or Foreign Country) MARYLAND						
LOR	96. FACILITY NAME (If not institution, give stre HARBOR HOSPITA)	L CENTER		BALT	N OR LOCATION OF D	EATH	eath 9c. county of Death N/A						
DIRECTOR	100. STATE 10b. COUNTY BALT:	IMORE	10c. CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
FUNERAL	100. STREET AND NUMBER 1900 WESTERN RU	UN RD.			10f. ZIP CODE 21030		N OF WHAT COUNTRY?						
B∡	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	II yes,	DECENDENT OF HISPA specify Cuben, Mexic (ES 2 NO Speci	. RACE — American Indian, Black, White, etc. Specify: WHITE							
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of w life. Do NOT us	USUAL OCCUPA vork done during e retired.)	ATION most of working	16b. KIND OF BU		TRY					
MPL		5+`	URBAN 1	DEVELO	PMENT	URBAN	DEVE	LOPMENT)					
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden	Sumame)						
BE	WILLIAM BOUCHER	R JR.				BETH BRY							
2	190. INFORMANT'S NAME (Type/Print) ANNE C. BOUCHE	3				Route Number, City or Tow		LLE,MD.21030					
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov	20b.	PLACE AND DATE O	F DISPOSITION	(Name of	DATE 20c. LC	CATION — City	or Town. State					
	4 Donation 5 Other (Specify)	G	REEN MO			Y11/95 B	ALTO.,	, MD.					
	21. SIGNATURE OF FUNERAL SERVICE LICE	Pava III	•	HEN	AND ADDRESS OF FA	ENKINS & RD. BALT(SONS	CO.					
	23. PART i. Enter the diseases, or con	mplications that ceused	the death. Do n	ot anter the	moda of dying, suc	th as cardiac or reap	iretory arrest	Approximata interval Between					
	IMMEDIATE CAUSE (Finel												
	disease of condition resulting in death) - Trabable Michael at Infart. a) Due to (or as a consequence of):												
z	Colosomy partery distrist												
CERTIFICATION	Sequentielly list conditiona, if any, leeding to immediate ceuse. Enter UNDERLYING	Sequentielly list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):											
	CAUSE (Disease or injury thet initiated events	ATMEN ICLE	CONSEQUENCE OF		. P. Dom. A			10+ YAS					
E	resulting in death) LAST			,.									
	PART ii. Other algnificant conditions	contributing to death by	it not resulting I	n the underly	las sauss alves le	Dial la mai							
CAL	ATRIAN F.32LLL		it not resulting i	n the underly	ing ceuse given in	PERFO	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE					
MEDIC	S/P Byeau due	wer (1987)				1 TYES 2	25 NO	OF DEATH?					
	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	DEATH YE	S 🗆 NO	☐ UNCERTAI	N IX		1 - YES 2 X NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF DEAT		ne)								
IXSI	1 TYES 2 NO	☐ Inpatient 2 ☐ ER/Outpo	rtient 3 DOA	OTHER: 4 Nursing H	ome 5 🗆 Residence	6 C Other (Specify)							
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	JRY	NJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED					
B√	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, term, at		YES 2 NO	281, LOCATION (Street	and Number or F	Rural Brutta Number					
Ë	4 Homicide determined	building, etc. (Speci	(y)			City or Town, State)		, , , , , , , , , , , , , , , , , , , ,					
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowled On the basis of examination	edge, death occurre	d at the time, d	ite end plece, end due	to the cause(e) end men time, date end place, en	nner ee stated.	euse(e) end manner ee stated.					
BE C	29b. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NUI	WBER	29d. DATE SI	GNED (Month, Day, Year)					
2		aust hi).) 1239	7	Nove	m36e 14, 1991					
-	30. NAME AND ADDRESS OF PERSON WHO CHARLES O DONOV	AN M.D. 65			ES ST T	OMSON MO	212	0.4					
	31. DATE THEP Month Day 1995	32. REGISTRAR'S SIGNA	TURE	O11111/17		. OWSON, MD	. 414	04.					
	W. T 1999	THE WASHINGTON	Mall										

